NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
Madison, WI

GROUP DENTAL INSURANCE CERTIFICATE

Underwritten by: National Guardian Life Insurance Company
(called “We”, “Our”, and “Us”)
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: beam

Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275

Physical Address
80 E. Rich St, Suite 400
Columbus, OH 43215

This Certificate explains the dental insurance coverage under the Group Policy (the Policy) issued to the Policyholder. The Policy provides the benefits for the Insured Member (called "You" or "Your") and any Covered Dependents.

The Policyholder and the Policy Number are shown in the Schedule of Benefits.

This, together with the Schedule of Benefits applying to Your Eligible Class, forms Your Certificate of Insurance while covered under the Policy. It replaces any previous Certificates of Insurance issued under the Policy to You.

This Certificate provides a general description of Your dental benefits. All benefits are governed by the terms and conditions of the Policy.

The Policy alone constitutes the entire contract between the Policyholder and Us. You may examine the Policy during regular business hours by contacting the Policyholder.

Kimberly A. Shaul, Secretary

Knut A. Olson, President

NON-PARTICIPATING

THIS IS A LEGAL CONTRACT – PLEASE READ YOUR CERTIFICATE CAREFULLY

DISPUTE RESOLUTION: Should a dispute arise concerning the policy or the payment of a claim hereunder, contact us in writing at the address shown above. If a dispute is not resolved to your satisfaction, you may contact the Consumer Services Division of the California Department of Insurance at 300 S. Spring Street, Los Angeles, CA 90013 or by phone at 1-800-927-HELP (1-800-927-4357); TDD: 800-4TDD (4833) or visit the California Department of Insurance web site at www.insurance.ca.gov.

You may also contact the Administrator. The contact information is shown above.

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PART I. DEFINITIONS

Administrator - The entity which will provide complete service and facilities for the writing and servicing of this policy as agreed in a contract with Us.

Calendar Year Plan - Benefits begin anew on January 1 of each Calendar Year.

Claim - A statement signed by an Insured and Their treating dentist for a request of payment under a dental benefit plan. It shall include services rendered, dates of services and itemization of costs.

Covered Dependent – Means an Eligible Dependent who is insured under this Certificate.

Covered Expense - The lesser of the following for a Covered Procedure: (1) the actual charge; or (2) the Maximum Reimbursement.

Covered Procedure - The procedures listed in the Schedule of Covered Procedures. The procedure must be: (1) for performed dental treatment to an Insured while Their coverage under this Certificate is in force and (2) for treatment, which in Our opinion has a reasonably favorable prognosis for the patient. The procedure must be performed by a licensed Dental Provider.

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

Dental Provider means an oral health care provider working within the scope of Their license, in the state in which services are received; including but not limited to:

1. licensed dentist, DDS or DMD;
2. licensed physician, MD, performing dental services;
3. licensed dental hygienist acting under the supervision and direction of a dentist.
4. licensed dental therapist acting under the supervision or direction of a dentist.

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

Eligible Dependent - Means a person listed below:

1. Your Spouse;
2. Your dependent child under age 26, who is Your natural or adopted child, Your Spouse's child, a foster child, or a child for whom You are a legal guardian and who is primarily dependent on You for support and maintenance.
3. Your child who has reached age 26 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of physically or mentally disabling injury, illness, or condition.

   Proof of the child's incapacity and dependency must be furnished to Us for an already enrolled child at least 60 days before the child reaches the limiting age, or when You enroll a new disabled child under the plan. We will notify You at least 90 days before the dependent child reaches the limiting age that you must provide the proof described in items a. and b. above. You must provide this proof within 60 days of receipt of notice from us. We will make a determination based on the proof provided. We will notify You of Our decision by the date the dependent child reaches the limiting age.

Eligibility Period – The period a Member must wait before They are eligible for coverage. The Eligibility Period, if any, is specified in the Policyholder's Group Application and shown in the Schedule of Benefits.

Initial Term - The period following the group's initial effective date and shown in the Schedule of Benefits. Rates are guaranteed not to change during this period.

In-Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are provided by a Participating Provider.

Insured – Means You and each Covered Dependent.

Insured Member– Means a person:
1. who is a Member of an Eligible Class; and
2. who has qualified for insurance by completing the Eligibility Period, if any; and
3. for whom insurance under the Policy has become effective.

Maximum Reimbursement – An amount used to determine the maximum amount to reimburse Participating and Non-Participating Provider charges for Covered Expenses. There are four types of Maximum Reimbursement, depending on the plan issued:

1. **Allowable Charge (AC):** When a Non-Participating Provider performs a Covered Procedure, the Allowable Charge is determined to be the lesser of: (a) the actual dental charge; or (b) the "customary charge" for the dental Service. We determine the "customary charge" from within the range of charges made for the same Service by other providers of similar training or experience in that general geographic area. When a Participating Provider performs a Covered Procedure, the Allowable Charge is determined to be the lesser of: (a) the actual dental charge; or (b) the amount that the Dentist has agreed with Us to accept as payment in full for a dental Service.

2. **Maximum Allowable Charge (MAC):** When a Non-Participating Provider performs a Covered Procedure, the MAC is determined to be the lesser of: (a) the actual dental charge; or (b) the 95th percentile of the "customary charge" for the dental Service. The "customary charge" is determined from charges made for the same Service by other providers of similar training or experience in that general geographic area. When a Participating Provider performs a Covered Procedure, the MAC is determined to be the lesser of: (a) the actual dental charge; or (b) the amount the dentist has agreed with Us to accept as payment in full for a dental Service.

3. **Scheduled Allowable Fee (SAF)**: Some plans may use a fee schedule to determine the amount payable for a Covered Procedure. This is the maximum charge that We allow for each Covered Procedure, regardless of the fee charged by the dentist. The Scheduled Allowable Fee for a Participating Provider may be different than the Scheduled Allowable Fee for a Non-Participating Provider.

4. **Indemnity**: The Maximum Allowable Charge (MAC), as explained in item 2. above, is used to determine the amount payable for a Covered Procedure. However, the reimbursement will be the same, regardless of whether a Participating Provider or Non-Participating Provider is used.

The Schedule of Covered Procedures shows the Type of Maximum Reimbursement used by the plan.

Member – Means a person who belongs to an Eligible Class of the Policyholder.

Non-Participating Provider - A dentist who is not a Participating Provider. These dentists have not entered into an agreement with Us to limit their charges.

Out-of-Network Benefits - The dental benefits provided under this Certificate for Covered Procedures that are not provided by a Participating Provider.

Participating Provider - A dentist who has been selected by Us for inclusion in the Participating Provider Program. These Participating Providers accept an agreed upon amount as payment in full for services rendered. When dental care is given by Participating Providers, the Insured will generally incur less out-of-pocket cost for services rendered.

Participating Provider Program - Our program to offer an Insured the opportunity to receive dental care from dentists who are designated by Us as Participating Providers.

Participating Provider Program Directory - The list which consists of selected dentists who:
1. are located in Your area; and

2. have been selected by Us to be Participating Providers and part of the Participating Provider Program.

The list will be periodically updated and is subject to change without notice.

Policyholder - The entity stated on the front page of the Policy.

Policy Year Plan - Benefits begin immediately on the Policyholder's effective date and renew 12 months following the initial effective date.

Spouse – Your Spouse or domestic partner:
1. By marriage; or
2. By a union between two adults having the effect of marriage that is recognized by law in the state where You reside; or
3. By a mutual agreement, recognized by the Policyholder, between two consenting adults who:
   a. are not married or legally separated;
   b. occupy the same residence; and
   c. share household expenses.

They, Them and Their – Refers to the male or female gender.

You or Your – The Insured Member.

Waiting Period - The period during which an Insured's coverage must be in force before benefits may become payable for Covered Procedures. The Waiting Period, if any, for each Covered Procedure is shown in the Schedule of Covered Procedures.

PART II. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

To be eligible for coverage under the Policy, an individual must:
1. be a Member of an Eligible Class of the Policyholder, as defined in the Schedule of Benefits; and
2. satisfy the Eligibility Period, if any.

The Member's Eligible Dependents are also eligible for coverage, provided that Dependent coverage is provided under the Policy.

Dual Eligibility Status: If both a Member and Their Spouse are in an Eligible Class of the Policyholder, enrollment will default to the Policyholder's rules.

B. ENROLLMENT

The term "Enrollment" means written or electronic application for coverage on an enrollment form furnished or approved by Us. Coverage will not become effective until the Members have enrolled themselves and Their Eligible Dependents, and paid the required premium, if any.

Initial Enrollment: Members should enroll themselves and Their Eligible Dependents within thirty (30) days of the Eligibility Period.

Open Enrollment: Members may enroll themselves and Their Eligible Dependents during an open enrollment period. Open enrollment is a period of time specified by the Policyholder and approved by Us. It usually occurs once each Calendar Year but may, at Our discretion, occur more frequently. Other changes may also be restricted to Open Enrollment periods.

Change in Family Status: Members may enroll or change Their coverage if a change in family status occurs, provided written application to enroll is made within sixty (60) days of the event. A change in family status means any of the following events:
1. Marriage; or domestic partnership;
2. Divorce or legal separation;

3. Birth or adoption of a child;
4. Death of a spouse or child;
5. Other changes as permitted by the Policyholder.

PART III. INDIVIDUAL EFFECTIVE DATES

Your coverage will be effective on the later of the following dates, provided that any required premium is paid to Us:
1. the Policyholder's Effective Date, shown on the Schedule of Benefits; or
2. the date You meet all the Eligibility and Enrollment requirements.

For Eligible Dependent acquired after Your effective date of coverage by reason of marriage, domestic partnership, birth, or adoption, coverage is effective on the date such dependent is acquired. This is subject to Our receipt of the required Enrollment and payment of the premium, if any.

Newborn Coverage: Any child born to You or Your Covered Dependent Spouse is covered from the moment of birth to thirty (30) days. A notice of birth, together with any additional premium, must be submitted to Us within thirty (30) days of the birth in order to continue the coverage beyond the initial thirty (30) day period.

Adopted Children: A child adopted by You is covered from the date of placement. Coverage will continue unless the child's placement is disrupted prior to legal adoption. A notice of placement for adoption, together with any additional premium, must be submitted to Us within thirty (30) days of the placement in order to continue the coverage beyond the initial thirty (30) day period.

PART IV. INDIVIDUAL TERMINATION DATES

Coverage for You and all Covered Dependents stops on the earliest of the following dates:
1. the date the Policy terminates;
2. the date the Policyholder's coverage terminates under the Policy;
3. the last day of the month in which You are no longer an eligible Member;
4. the date You die;
5. the last day of the Grace Period, if full payment for Your insurance is not made within the Grace Period following the premium due date.

In addition, coverage for each Covered Dependent stops on the earliest of:
1. the date They are no longer an Eligible Dependent;
2. the date We receive Your request to terminate Covered Dependent coverage.

PART V. INDIVIDUAL PREMIUMS

Members may be required to contribute, either in whole or in part, to the cost of Their insurance. This is subject to the terms established by the Policyholder. Your premium contributions, if required, are remitted to Us in one of two ways:
1. You contribute to the cost of the insurance through the Policyholder, who then submits payment to Us; or
2. You pay Your premiums directly to Us.

The Schedule of Benefits shows the method of premium payment.

The first premium is due on the Effective Date. Premiums after the first are due on the Premium Due Date or within the grace period.

Grace Period: A grace period of thirty-one (31) days (without interest charge) is granted for the payment of each premium due after the first. The coverage stays in force if the premium is paid during this grace period, unless We are given written notice that the insurance is to be ended before the Grace Period. If the premium is not paid by the end of the Grace Period, all insurance under this Policy will end on the last day of the Grace Period. The Policyholder will owe Us all premiums then due and unpaid including the premium for the Grace Period.

Right to Change Premiums: We have the right to change the premium rates on any premium due date on or after the Initial Term. After the Initial Term, We will not increase the premium rates more than once in a twelve (12) month

period. We will give the Policyholder written notice at least forty-five (45) days in advance of any change. All changes in rates are subject to terms outlined in the Policy.

PART VI. DESCRIPTION OF COVERAGE

A. COVERED DENTAL EXPENSES

We determine if benefits are payable based on the definitions and provisions under the policy and Certificate when an Insured incurs expenses for a Covered Procedure. The Insured must satisfy the Deductible and Waiting Period, if any, before the determination is made.

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

We then pay the Insurance Percentage of the Covered Expense. The Insurance Percentage is shown in the Table of Insurance Percentages on the Schedule of Benefits.

The benefit is subject to the following:

1. The Covered Procedure must start and be completed while the Insured's coverage is in force, except as provided in the Takeover Benefits provision, if applicable.
2. Each Covered Procedure may be subject to specific Limitations, as shown on the Schedule of Covered Procedures.
3. A Certificate Year Maximum Annual Benefit may apply to each Insured. This is shown on the Schedule of Benefits.
4. A Maximum Annual and/or Maximum Lifetime Benefit may apply to each Procedure Class. If applicable, these maximums are shown in the Table of Covered Insurance Percentages on the Schedule of Benefits.
5. Other limitations and exclusions that may affect coverage are shown in the "Limitations and Exclusions" provision.

B. WHEN A COVERED PROCEDURE IS STARTED AND COMPLETED

1. We consider a dental treatment to be started as follows:
   a. for a full or partial denture, the date the first impression is taken;
   b. for a fixed bridge, crown, inlay and onlay, the date the teeth are first prepared;
   c. for root canal therapy, on the date the pulp chamber is first opened;
   d. for periodontal surgery, the date the surgery is performed; and
   e. for all other treatment, the date treatment is rendered.

2. We consider a dental treatment to be completed as follows:
   a. for a full or partial denture, the date a final completed prosthesis is first inserted in the mouth;
   b. for a fixed bridge, crown, inlay and onlay, the date the bridge or restoration is cemented in place; and
   c. for root canal therapy, the date a canal is permanently filled.

NOTE: Orthodontic treatment is subject to different start and completion date rules. See the Orthodontia Services provision for details.

C. ORTHODONTIA SERVICES

We will pay orthodontia benefits for Insureds for the services and treatment listed in the Schedule of Covered Procedures, that are started while covered under this Certificate.

We consider orthodontic treatment to be started on 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.

No payment will be made for orthodontic treatment if Bands or Appliances are inserted prior to the Insured's effective date except as provided in the Takeover Benefits provision.

Any limitations regarding orthodontia coverage are indicated in the Schedule of Covered Procedures.

We will pay the Insurance Percentage shown in the Schedule of Benefits after any deductible has been satisfied for the Certificate Year. The maximum benefit payable to each Insured, while insured under the policy, for orthodontic services is shown in the Schedule of Benefits. The maximum benefit will apply even if coverage is interrupted.

We will make a payment for covered orthodontic services related to the initial orthodontic treatment which consists of diagnosis, evaluation, pre-care and insertion of Bands or Appliances. After the payment for the initial orthodontic treatment, benefits for covered orthodontic services will be paid in monthly installments as claims are submitted over the course of the remaining treatment.

The benefit payment schedule for the initial orthodontic treatment and installments will be determined as follows:

1. We will determine the lesser of the Maximum Allowable Charge and the Orthodontist's fee and multiply that amount by the Insurance Percentage shown in the Schedule of Benefits.
2. The lesser of the amount from number 1 or the Overall Maximum Benefit for orthodontic services shown in the Schedule of Benefits will be the maximum benefit payable. An initial amount of 25% of the Overall Maximum Benefit payable will be paid for the initial orthodontic treatment. This amount will be payable as of the date Appliances or Bands are inserted.
3. The remaining 75% of the Overall Maximum Benefit payable will be paid at the applicable coinsurance on a monthly basis as claims are submitted. The subsequent payments will be made only if the Insured remains covered under this Certificate and provides proof to Us that orthodontic treatment continues.

No further benefits will be paid for orthodontic treatment received after the Overall Maximum Benefit has been met.

The lifetime maximum is equal to the member's lifetime maximum and is inclusive with the prior carrier, if applicable.

Additional Definitions Used in This Benefit:

Appliance means any device, attached to the teeth or removable, designed to move the teeth, change the position of the jaw, or hold the teeth in their finished positions after braces or aligners are removed.

Band means a metal ring, usually on a back tooth, that is cemented to a tooth for strength and anchorage.

Orthodontist means a Dental Provider who specializes in the diagnosis, prevention, interception, and treatment of malocclusions or bad bite, of the teeth and surrounding structures.

Orthodontist-Directed At-Home Clear Aligner Treatment

We will pay a benefit for Orthodontist-Directed At-Home Clear Aligner Treatment, at the benefit percentage for Orthodontia Services stated in the Schedule of Benefits.

You must pay the service provider in full at the time services are rendered, and submit the claim to Us, regardless of the provider's network status. Please see PART VIII. CLAIM PROVISIONS, for details on how to submit a claim.

This benefit is subject to the Orthodontia Services Overall Maximum Benefit. No further benefits will be paid for orthodontic treatment received after the Overall Maximum Benefit has been met.

The lifetime maximum is equal to the member's lifetime maximum and is inclusive with the prior carrier, if applicable.

D. CARRYOVER BENEFITS

An Insured may be eligible to carryover of a portion of Their unused Certificate Year Maximum Benefit, as follows:

If an Insured submits Qualifying Claims for Covered Expenses during a Benefit Year and, in that Benefit Year, receives benefits that are in excess of any deductible, and that, in total, do not exceed the Threshold Limit, the Insured will be credited a Carryover Benefit for that Benefit Year. In addition, the Insured must have at least one cleaning and one routine exam per year.

Carryover Benefits will be accrued and stored in the Insured's Carryover Account. If an Insured reaches Their Certificate Year Maximum Benefit, We will pay a benefit from the Insured's Carryover Account up to the amount stored in the Insured's Carryover Account. The accrued Carryover Benefits stored in the Carryover Account may not be greater than the Carryover Account Limit.

If the Insured has a break in coverage of any length of time, for any reason, Their Carryover Account will be eliminated, and the accrued Carryover Benefits lost.

The Threshold Limit, Carryover Benefit, and Carryover Account Limits are stated in the Schedule of Benefits.

Eligibility for a Carryover Benefit will be established or reestablished at the time the first Qualifying Claim in a Benefit Year is received for Covered Expenses incurred during that Benefit Year.

In order to properly calculate the Carryover Benefit, claims should be submitted timely in accordance with the Proof of Loss provision found within the Claims Provision. You have the right to request review of prior Carryover Benefit calculations. The request for review must be within 12 months from the date the Carryover Benefit was established.

Benefit Accrual Specifications

For Calendar Year Plans: If coverage is first effective on any date other than January 1, this benefit will not become effective until January 1 of the first full Calendar Year. If an Insured's effective date of coverage is in October, November or December, this rider will not apply to the Insured until January 1 of the next Calendar Year. In either case:

- Only claims incurred on or after the start of the next Calendar Year will count toward the Threshold Limit;
- Requirement of one (1) cleaning and one (1) exam incurred after January 1; and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Calendar Year that starts one year from the date the rider first applies

If Covered Insurance Percentages increase each Benefit Year for certain Covered Procedures, this benefit will not apply to the Insured until all Covered Insurance Percentages reach the ultimate level. If the Covered Insurance Percentages reach the ultimate level within the three months prior to the start of this plan's next Benefit Year, this benefit will not apply to the Insured until the next Benefit Year, and:

- Only claims incurred on or after the start of the next Benefit Year will count toward the Threshold Limit; and
- Carryover Benefits will not be applied to an Insured's Carryover Account until the Benefit Year that starts one year from the date the benefit first applies.

Additional conditions for accrual of the Carryover Benefit may apply based on the Policyholder's Status, as stated in the Schedule of Benefits.

Additional Definitions as Used in This Benefit:

Benefit Year means the Calendar Year, according to the type of plan applicable under the Certificate

Carryover Account means the Calendar Year, according to the type of plan applicable under the

Carryover Account Limit means the maximum amount of cumulative Carryover Benefits that an Insured can store in Their Carryover Account.

Carryover Benefit means the dollar amount, which will be added to an Insured's Carryover Account when They receive benefits in a Benefit Year that do not exceed the Threshold Limit.

Qualifying Claim means a claim under Procedure Classes A, B, C and must include 1 exam and 1 cleaning.

Threshold Limit means the maximum amount of benefits that an Insured can receive during a Benefit Year and still be entitled to receive the Carryover Benefit. This includes all claims processed under all Procedure Classes.

E. HOW TO SUBMIT EXPENSES

Expenses submitted to Us must identify the treatment performed in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature or by narrative description. We reserve the right to request x-rays, narratives and other diagnostic information at Our own expense, as We see fit, to determine benefits.

F. CHOICE OF PROVIDERS

An Insured may choose a dentist of Their choice. An Insured may choose the services of a dentist who is either a Participating Provider or a Non-Participating Provider. Benefits under this Certificate are determined and payable in either case. If a Participating Provider is chosen, the Insured will generally incur less out-of-pocket cost unless the Policyholder has selected a Participating Provider Only plan.

If appropriate care cannot be provided within the Network, the Administrator will contact the Network to arrange the required care with an available and accessible Non-Participating Provider. The Insured will only be responsible for the cost-sharing amount that would have been due for the same services if received from a Participating Provider.

Note: If this is an Indemnity plan, there is no difference in payment between a Participating and Non-Participating Provider.

G. PRE-ESTIMATE

If the charge for any treatment is expected to exceed $300, We suggest that a dental treatment plan be submitted to Us by Your dentist for review before treatment begins. In addition to a dental treatment plan, We may request any of the following information to help Us determine benefits payable for certain services:

1. full mouth dental x-rays;
2. cephalometric x-rays and analysis;
3. study models; and
4. a statement specifying:
    a. degree of overjet, overbite, crowding and open bite;
    b. whether teeth are impacted, in crossbite, or congenitally missing;
    c. length of orthodontic treatment; and
    d. total orthodontic treatment charge.

An estimate of the benefits payable will be sent to You and Your dentist. The pre-estimate is not a guarantee of the amount We will pay. The pre-estimate process lets an Insured know in advance approximately what portion of the expenses We will consider as a Covered Expense. Our estimate may be for a less expensive alternative benefit if it will produce professionally satisfactory results.

H. ALTERNATE BENEFIT PROVISION

Many dental problems can be resolved in more than one way. If: 1) We determine that a less expensive alternative benefit could be provided for the resolution of a dental problem; and 2) that benefit would produce the same resolution of the diagnosed problem within professionally acceptable limits, We may use the less expensive alternative benefit to determine the amount payable under the Certificate. For example: When an amalgam filling and a composite filling are both professionally acceptable methods for filling a molar, We may base Our benefit on the amalgam filling which is the less expensive alternative benefit. This is the case whether a Participating Provider or Non-Participating Provider performs the service.

I. SERVICES PERFORMED OUTSIDE THE U.S.A.

Any Claim submitted for procedures performed outside the U.S.A. must: (1) be for a Covered Procedure, as defined; (2) be supplied in English; (3) use American Dental Association (ADA) codes; and (4) be in U.S. Dollar currency. Reimbursement will be based on the Maximum Allowable Charge amounts for the Insured's zip code.

J. TIMELY ACESSS TO CARE WHEN INSURED VISITS A NETWORK PROVIDER

1. If rescheduling an appointment with a Network Provider is necessary, the appointment will be reschedule as soon as possible as appropriate to the Insured's needs;
2. Interpreter services will be coordinated with scheduled appointment;
3. During normal business hours, the wait time for a Insured to speak by telephone with Our customer service representatives will not be longer than 10 minutes. If the wait will be longer, the Insured will receive a call back within 30 minutes.
4. The Participating Provider must provide an answering service or voicemail service during non-business hours. The service must provide instruction regarding emergency care. If another provider is on-call, the services should provide information on how to contact that provider.
5. Urgent appointments will be offered within 72 hours of the request for an appointment;
6. Non-urgent appointments will be offered within 36 business days of the request for an appointment.
7. Preventive appointments will be offered within 40 days of the request for an appointment.

K. If Your Network Provider Leaves the Network: You may complete a course of treatment with that Provider at the Network cost-share level if the course of treatment is for any of the conditions listed:

1. An acute medical condition that involves sudden onset of symptoms because of a disease, illness, or other medical problem that requires prompt medical attention and has a limited duration. The services of the Provider are covered for the duration of that acute condition only.
2. A serious chronic condition caused by disease or other medical problem or disorder that persists without full care or worsens over an extended period of time. Services of the Provider are Covered to complete a course of treatment and to arrange for safe transfer to another provider within the Network. Completion of the covered services will not exceed 12 months from the date the Provider's contract terminated or 12 months from the effective date of coverage for a newly covered Insured.
3. Surgery or other procedure that is recommended and documented by the Provider to occur within 180 days of the Provider's contract termination date or 180 days of the Insured's effective date of coverage for a newly covered insured.

Contact the Administrator listed on the cover of this Certificate for authorized completion of the course of treatment.

PART VII. LIMITATIONS AND EXCLUSIONS

A. LIMITATIONS

IMPORTANT: If you choose to receive dental services that are not Covered Expenses under this plan, a Participating Provider may charge the usual and customary rate when providing those services. Before providing an Insured with services that are not a Covered Expenses, the Participating Provider should provide to the Insured a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call 1-800-648-1179.

1. Other Limitations:

a. Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations.
b. Coverage is limited to one (1) full mouth radiograph or panoramic film per limitation period listed in the Schedule of Covered procedures.
c. On any given day, more than seven (7) periapical x-rays or panoramic film in conjunction with bitewings will be paid as a full mouth radiograph.

Additional limitations are noted in the Schedule of Covered Procedures.

B. EXCLUSIONS

No benefits are payable under the Policy for the procedures listed below unless such procedure or service is listed as covered in the Schedule of Covered Procedures. Excluded procedures will not be recognized toward satisfaction of any Deductible amount.

1. any service or supply not shown on the Schedule of Covered Procedures;
2. any procedure begun after an Insured's insurance under the Policy terminates, or for any prosthetic dental appliance finally installed or delivered more than thirty (30) days after an Insured's insurance under the Policy terminates;
3. any procedure begun or appliance installed before an Insured became insured under the Policy;
4. any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior cosmetic restorations;
5. the correction of congenital malformations or congenital missing teeth;
6. the replacement of lost or discarded or stolen appliances;
7. replacement of bridges unless the bridge is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
8. replacement of full or partial dentures unless the prosthetic appliance is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
9. replacement of implants, crowns, inlays or onlays unless the prior restoration is older than the age allowed in the Schedule of Covered Procedures and cannot be made serviceable;
10. appliances, services or procedures relating to: (a) the change or maintenance of vertical dimension; (b) restoration of occlusion (unless otherwise noted in the Schedule of Covered Procedures—only for occlusal guards); (c) splinting; (d) correction of attrition, abrasion, erosion or abfraction; (e) bite registration or (f) bite analysis;
11. services provided for any type of temporomandibular joint (TMJ) dysfunctions, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain;
12. orthognathic surgery;
13. prescribed medications, premedication or analgesia;
14. any instruction for diet, plaque control and oral hygiene;
15. dental disease, defect or injury caused by a declared or undeclared war or any act of war;
16. charges for: implants of any type, and all related procedures, removal of implants, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments;
17. cast restorations, inlays, onlays and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means (such as an amalgam or composite filling);
18. for treatment of malignancies, cysts and neoplasms;
19. for orthodontic treatment;
20. charges for failure to keep a scheduled visit or for the completion of any Claim forms;
21. any procedure which is not necessary, does not offer a favorable prognosis, or does not have uniform professional endorsement or which is experimental in nature;
22. service or supply rendered by someone who is related to an Insured by blood or by law (e.g., sibling, parent, grandparent, child), marriage (e.g., spouse or in-law) or adoption or is normally a member of the Insured's household;
23. expenses paid by Workers' Compensation or Employers' Liability Laws or by any coverage provided or required by law (including, but not limited to, group, group-type and individual automobile "No-Fault" coverage);
24. expenses provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay or as addressed later under the "Payment of Claims" provision;
25. procedures started but not completed;
26. any duplicate device or appliance;
27. general anesthesia and intravenous sedation except in conjunction with covered complex oral surgery procedures as defined by Us, plus the services of anesthetists or anesthesiologists;
28. the replacement of 3rd molars;
29. crowns, inlays and onlays used to restore teeth with micro fractures or fracture lines, undermined cusps, or existing large restorations without overt pathology.

PART VIII. CLAIM PROVISIONS

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

National Guardian Life Insurance Company
c/o Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275

Claim Forms: When the Administrator receives notice of Claim that does not contain all necessary information or is not on an appropriate Claim form, forms for filing proof of loss will be sent to the claimant along with a request for the missing information. If these forms are not sent within fifteen (15) days after receiving notice of claim, the claimant will meet the proof of loss requirements if the Administrator is given written proof of the nature and extent of the loss.

Proof Of Loss: Written proof of loss must be given to the Administrator within ninety (90) days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one (1) year after it is due, unless You are legally incapable of doing so.

Payment Of Claims: Benefits will be paid to You unless an Assignment of Benefits has been requested by the Insured. Benefits due and unpaid at Your death will be paid to Your estate. Any payment made by Us in good faith pursuant to this provision will fully release Us to the extent of such payment.

If any beneficiary is a minor or mentally incapacitated, We will pay the proper share of Your insurance amount to such beneficiary's court appointed guardian.

Time of Payment of Claims: Benefits payable under this policy will be paid within thirty (30) days of receipt of written proof of loss.

Recovery Of Overpayments: We reserve the right to deduct from any benefits properly payable under this Policy the amount of any payment that has been made to the Insured:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within two (2) years after the date such coverage commences; or
4. with respect to an ineligible person; or
5. pursuant to a claim for which benefits which have been paid under any Policy or act of law providing coverage for occupational injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future claim for benefits under the Policy made by an Insured if claim payments previously were made with respect to an Insured.

PART IX. COORDINATION OF BENEFITS (COB)

This provision applies when an Insured has dental coverage under more than one Plan, as defined below. The benefits payable between the Plans will be coordinated.

A. DEFINITIONS RELATED TO COB

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

2. **Coordination of Benefits:** Taking other Plans into account when We pay benefits.

3. **Plan:** Any plan, including this one that provides benefits or services for dental expenses on either a group or individual basis. “Plan” includes group and blanket insurance and self-insured and prepaid plans. It

includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). “Plan” shall be treated separately for that part of a plan that reserves the right to coordinate with benefits or services of other plans and that part which does not.

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

5. **Year:** The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

B. BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Insured’s Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of COB.

If an Insured’s benefits paid under this Plan are reduced due to COB, each benefit will be reduced proportionately. Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

C. THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a COB provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a COB provision, the order of benefit payment is as follows:

    a. **Non-dependent/Dependent.** A Plan that covers a person other than as a dependent will pay before a Plan that covers that person as a dependent.

    b. **Dependent Child/Parents Not Separated or Divorced**. For a dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan that has covered the dependent child for the longer period will pay first. If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

    c. **Dependent Child/Separated or Divorced Parents**. If two (2) or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:
        i. The Plan of the parent who has responsibility for providing insurance as determined by a court order;
        ii. The Plan of the parent with custody of the child;
        iii. The Plan of the spouse of the parent with custody; and
        iv. The Plan of the parent without custody of the child.

    d. **Dependent Child/Joint Custody**. If the joint custody court decree does not specifically state which parent is responsible for the child’s medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

    e. **Active/Inactive Employee.** The Plan which covers the person as an employee who is neither laid off nor retired (or as that employee’s dependent) is Primary over the Plan which covers that person as a laid off or retired employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.

    f. **Longer/Shorter Length of Coverage**. When an order of payment is not established by the above, the Plan that has covered the person for the longer period of time will pay first.

D. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for

COB. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for COB.

E. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

COB may result in payments made by another Plan that should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

F. RIGHT TO RECOVERY

COB may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

PART X. GRIEVANCE PROCEDURE

If a claim for benefits is wholly or partially denied, the Insured will be notified in writing of such denial and of Their right to file a grievance and the procedure to follow. The notice of denial will state the specific reason for the denial of benefits. Within sixty (60) days of receipt of such written notice an Insured may file a grievance and make a written request for review to:

National Guardian Life Insurance Company
c/o Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended another thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

The Insured or someone on Their behalf also has the right to appear in person before Our grievance committee to present written or oral information and to question those people responsible for making the determination that resulted in the grievance. The Insured will be informed in writing of the time and place of the meeting at least seven (7) calendar days before the meeting.

For purposes of this Grievance Procedure, a grievance is a written complaint submitted in accordance with the above Grievance Procedure by or on behalf of an Insured regarding dissatisfaction with the administration of claims practices or provision of services of this panel provider plan relative to the Insured.

In situations requiring urgent care, grievances will be resolved within four (4) business days of receiving the grievance.

PART XI. GENERAL PROVISIONS

Cancellation: We may cancel the Policy at any time by providing at least sixty 60 days advance written notice to the Policyholder. The Policyholder may cancel the Policy at any time by providing written notice to Us, effective upon Our receipt on the notice or the date specified in the notice, if later. In the event of such cancellation by either Us or the Policyholder, We shall promptly return on a pro rata basis any unearned premium paid. The Policyholder shall promptly pay on a pro rata basis the earned premium which has not been paid, if any. Such cancellation shall be without prejudice to any claim originating prior to the effective date of such cancellation.

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

PART XII. TAKEOVER BENEFITS

The following provisions are applicable if this dental plan is replacing existing group dental plan in force (referred to

as “Prior Plan”) at the time of application. These are called “Takeover Benefits.” The Schedule of Benefits shows if Takeover Benefits apply.

Takeover benefits apply if We are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer’s dental plan in effect at the time of the employer’s application. If takeover benefits are included in Your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer’s previous plan during the month prior to coverage moving to National Guardian Life.

New hires with prior-like dental coverage (lapse in coverage must be less than sixty-three (63) days) will receive takeover credit for the length of time They had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e., one page benefit summary, certificate of creditable coverage, etc.).

Waiting Period Credit: When We immediately take over an entire dental group from another carrier, those persons insured by the Prior Plan on the day immediately prior to the takeover effective date will receive Waiting Period credit if They are eligible for coverage on the effective date of Our plan.

Annual Maximums And Deductible Credits: For Calendar Year Plans: Deductible credits will be granted for the amount of Deductible satisfied under the Prior Plan during the current Calendar Year. Any benefits paid under the Prior Plan with respect to such replaced coverage will be applied to and deducted from the maximum benefit payable under this Certificate.

For Policy Year Plans: The annual maximums and annual Deductibles will begin on the policy’s takeover effective date, which marks the start of a new Policy Year. Deductible credit will not be given. Any benefits paid under the Prior Plan with respect to such replaced coverage will not be applied to or deducted from the maximum benefits payable for services under this Certificate.

Maximum Benefit Credit: All paid benefits applied to the maximum benefit amounts under the Prior Plan will also be applied to the maximum benefit amounts under this Certificate.

If You had orthodontic coverage for Your covered dependent children under the Prior Plan and You have orthodontic coverage under this Certificate, We will not pay benefits for orthodontic expenses unless:

1. You submit proof that the Maximum Lifetime Benefit for Class D Orthodontic Services for this Certificate was not exceeded under the Prior Plan; and
2. orthodontic treatment was started and bands or appliances were inserted while insured under the Prior Plan; and
3. orthodontic treatment is continued while Your covered dependent is insured under this Certificate.

If You submit the required proof, the maximum benefit for orthodontic treatment will be the lesser of this Certificate’s Overall Maximum Benefit for Class D Orthodontic Services or the Prior Plan’s ortho maximum benefit. The ortho maximum benefit payable under this Certificate will be reduced by the amount paid or payable under the Prior Plan.

Verification: The Policyholder’s application must be accompanied by a current month’s billing from the current dental carrier, a copy of an in-force certificate, as well as proof of the effective date for each Insured (and dependent), if insured under the Prior Plan.

Prior Carrier’s Responsibility: The prior carrier is responsible for costs for procedures begun prior to the effective date of this coverage.

Prior Extractions: If: (1) treatment is performed due to an extraction which occurred before the effective date of this coverage while an Insured was covered under the Prior Plan; and (2) the replacement of the extracted tooth must take place within twelve (12) months of extraction; and (3) treatment would have been covered under the Policyholder’s Prior Plan; We will apply the expenses to this plan as long as They are Covered Expenses under both this Certificate and the Prior Plan.

Coverage for Treatment in Progress: If an Insured was covered under the Prior Plan on the day before this Certificate replaced the Prior Plan, the Insured may be eligible for benefits for treatment already in progress on the effective date of this Certificate. However, the expenses must be covered dental expenses under both this Certificate and the Prior Plan. This is subject to the following:

1. Extension of Benefits under Prior Plan. We will not pay benefits for treatment if:
   (a) the Prior Plan has an Extension of Benefits provision;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed during the extension of benefits.
2. 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:
   (a) the Prior Plan has no extension of benefits when that plan terminates;
   (b) the treatment expenses were incurred under the Prior Plan; and
   (c) the treatment was completed while insured under this Certificate.
3. 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:
   (a) the Prior Plan has an extension of benefits;
   (b) the treatment expenses were incurred under the Prior plan; and
   (c) the treatment was not completed during the Prior Plan's extension of benefits.

We will consider only the percentage of treatment completed beyond the extension period to determine any benefits payable under this Certificate.

PART XIII. SCHEDULE OF BENEFITS (WHO PAYS WHAT)

Policyholder: Silicon Valley Mechanical

Policyholder's Address: San Jose, CA 95131

Effective Date: January 1st, 2023

Initial Term: 12 Months

Eligible Classes: All full time employees working at least 30 hours per week

Eligibility Period: First of the month following 0 Days from the first day of Active Work

Mode of Premium Payment: Monthly

Method of Premium Payment: Remitted by Policyholder

Premium Due Date: 1st of every month

Certificate Year: Your Certificate Year is on a Calendar Year Plan

Deductible: In-Network: Applies to Classes: B, C

	Year 1	Year 2	Year 3+
Individual	$50	$50	$50
Maximum Deductibles per Family	3	3	3

Out-of-Network: B, C

	Year 1	Year 2	Year 3+
Individual	$50	$50	$50
Maximum Deductibles per Family	3	3	3

Certificate Year Annual Maximum: Per Insured

	Year 1	Year 2	Year 3+
In-Network	$2,000	$2,000	$2,000
Out-of- Network	$2,000	$2,000	$2,000

Waiting Periods: See Schedule of Covered Procedures

Carryover Benefit: Threshold Limit:
Carryover Benefit:

Carryover Account Limit:

Policyholder Status: This is a takeover group. Roll Forward Amounts will be accumulated based on the prior Plan Year's claim activity, subject to availability of applicable data from the prior insurance carrier.

Takeover Benefits: Do takeover benefits apply for Employees who currently have dental coverage? Yes

Plan Type:

☐ Indemnity: No Participating Provider Network

■ Participating Provider Program:

■ In- and Out-of-Network Benefits

☐ In-Network Benefits only

☐ Scheduled Fee Plan

TABLE OF INSURANCE PERCENTAGES:

Procedure Class Key
A - Preventive/Diagnostic
B - Basic
C - Major
D - Orthodontia
E - Not Covered

Certificate Year: All

Procedure Class	Insurance Percentage In-Network	Insurance Percentage Out-of-Network	Subject to Certificate Year Maximum	Maximum Benefit: Annual/Lifetime
Class A	100%	100%	Yes	$2,000/None
Class B	90%	80%	Yes	$2,000/None
Class C	60%	50%	Yes	$2,000/None
Class D	50%	50%	No	$2,000/$2,000
Class E	0%	0%	0%	$0

PART XIV. SCHEDULE OF COVERED PROCEDURES

The following is a complete list of Covered Procedures, their assigned Procedure Class, Waiting Period, and applicable limitations.
We will not pay benefits for expenses incurred for any Procedure not listed in the Schedule of Covered Procedures.

Key for Schedule of Covered Procedures

Procedure Class	Type of Maximum Reimbursement:
A - Preventive/Diagnostic	AC –Allowable Charge
B – Basic	MAC – Maximum Allowable Charge
C – Major	
D – Orthodontia	
E - Not Covered	

Limitations

(a) Maximum of 1 procedure per 6 months
(b) Maximum of 1 procedure per 36 months
(c) Maximum of 4 films per 12 months
(d) Limited to Dependent Children under age 19
(e) Maximum of 1 procedure per 12 months
(f) Limited to Dependent Children under age 14
(g) Limited to Dependent Children under age 12
(h) Maximum of 1 procedure per 24 months
(i) Limited to Dependent Children under age 19
(j) Applications made to permanent molar teeth only
(k) Maximum of 2 procedures per arch per 24 months
(l) Maximum of 1 per 5 year period per tooth
(m) Maximum of 1 each quadrant per 12 months
(n) Maximum of 1 each quadrant per 24 months
(o) Maximum of 1 each tooth per 24 months
(p) Subject to a yearly and a lifetime maximum
(q) Maximum of 1 each quadrant per 36 months
(r) Replacement of existing only if in place for 12 months (insured under age 19)
(s) Replace existing only if in place for 36 months (insured over age 19)
(t) Benefits will be based on the benefit for the corresponding non-cosmetic restoration.
(u) Maximum 1 time per tooth or site
(v) Maximum of 1 per lifetime
(w) Only in conjunction with listed complex oral surgery procedures and subject to review.
(x) Limited to Dependent Children under age 16
(y) Maximum of 1 per 24 months for age 17+
(z) Maximum of 1 per 12 months for age 16 & under
(aa) Limited to those age 25+
(bb) 6 months must have passed since initial placement
(cc) Maximum of 1 per 7 year period when existing appliance/restoration is not serviceable
(dd) Maximum of 1 per 10 year period
(ee) Maximum of 1 per 3 year period
(ff) Maximum of 1 per 4 year period
(gg) Maximum of 1 per 5 year period
(hh) In lieu of a single tooth replacement when a 2 or 3 unit bridge has been approved for coverage
(ii) Maximum of 2 procedures per 12 months
(jj) Only for those age 40 and over who demonstrate risk factors for oral cancer and/or a suspicious lesion
(kk) 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 the time of claim.
(ll) Two additional cleanings (either prophylaxis or periodontal maintenance) per year if Member has been diagnosed with diabetes mellitus and periodontal disease. Written verification of diabetes mellitus from patient's physician and claim narrative must be submitted at the time of the claim.
(mm) Covered only if provided on different date of service than other covered treatment or exam
(nn) Subject to review
(oo) In lieu of Topical Application of Fluoride for a child
(pp) Limited to 3 oral evaluation procedures, in any combination (D0120, D0150, D9310) per 12 month period
(qq) Maximum of 2 per quadrant per 24 month period
(rr) Reported in addition to other procedures delivered to the patient on the date of service

Covered procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
DIAGNOSTIC					
Comprehensive or periodic oral exam	A	0	pp	MAC	MAC
Oral evaluation – patient under 3 yrs of age	A	0	pp	MAC	MAC
Problem focused exam	A	0	ii	MAC	MAC
Re-evaluation – limited problem focused (not post-op visit)	A	0	e	MAC	MAC
Comprehensive periodontal exam	A	0	gg	MAC	MAC
Emergency palliative treatment	B	0	e	MAC	MAC
Professional consultation	A	0	e	MAC	MAC
Intra-oral – complete series	A	0	gg	MAC	MAC
Intra-oral - occlusal image	A	0	ii	MAC	MAC
Intra-oral – periapical, first image	A	0		MAC	MAC
Intra-oral – periapical, additional image	A	0		MAC	MAC
Bitewings (single or multiple images)	A	0	a	MAC	MAC
Panoramic image or full mouth x-ray	A	0	gg	MAC	MAC
Adjunctive pre-diagnostic oral cancer screening	A	0	e, jj	MAC	MAC
Accession of tissue, gross exam including report	A	0	nn	MAC	MAC
Accession of tissue, gross and micro exam including report	A	0	nn	MAC	MAC
Accession of tissue, gross and micro exam (including assessment of surgical margins) including report	A	0	nn	MAC	MAC
Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report	A	0	e, jj	MAC	MAC
PREVENTIVE					
Prophylaxis – adult	A	0	ii, kk, ll	MAC	MAC
Prophylaxis – child	A	0	f, ll	MAC	MAC
Topical application of fluoride – child	A	0	e, x	MAC	MAC
Topical fluoride varnish	A	0	e, x	MAC	MAC
Sealant	A	0	b, x, j	MAC	MAC
Space maintainer – fixed unilateral	A	0	x, o	MAC	MAC
Space maintainer – fixed bilateral	A	0	x, o	MAC	MAC
Space maintainer – removable unilateral	A	0	x, o	MAC	MAC
Space maintainer – removable bilateral	A	0	x, o	MAC	MAC
FILLINGS, RESTORATIONS					
One surface amalgam	B	0	o	MAC	MAC
Two surface amalgam	B	0	o	MAC	MAC
Three surface amalgam	B	0	o	MAC	MAC
Four + surface amalgam	B	0	o	MAC	MAC
One surface resin – anterior	B	0	o	MAC	MAC
Two surface resin – anterior	B	0	o	MAC	MAC

Covered procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
Three surface resin – anterior	B	0	o	MAC	MAC
Four + surface or incisal angle resin – anterior	B	0	o	MAC	MAC
One surface resin – posterior	B	0	o	MAC	MAC
Two surface resin – posterior	B	0	o	MAC	MAC
Three surface resin – posterior	B	0	o	MAC	MAC
Four + surface resin – posterior	B	0	o	MAC	MAC
Oral surgery					
Extraction, erupted tooth or exposed root	B	0		MAC	MAC
Coronal remnants	B	0		MAC	MAC
Surgical extraction	B	0		MAC	MAC
Removal of impacted tooth - soft tissue	B	0		MAC	MAC
Removal of impacted tooth - - partial bony	B	0		MAC	MAC
Removal of impacted tooth - complete bony	B	0		MAC	MAC
Surgical removal of root	B	0		MAC	MAC
Alveoloplasty (with extraction) – per quadrant	B	0	u	MAC	MAC
Alveoloplasty (without extraction) – per quadrant	B	0	u	MAC	MAC
Incision and drainage of abscess – intraoral	B	0	u	MAC	MAC
Frenectomy (by report, for periodontal purposes only)	B	0	u, v	MAC	MAC
General anesthesia/intravenous sedation	B	0	w	MAC	MAC
CROWN AND BRIDGE REPAIR					
Inlay recementation	B	0	u, bb	MAC	MAC
Crown recementation	B	0	u, bb	MAC	MAC
Bridge repair	B	0	u, bb	MAC	MAC
Bridge recementation	B	0	u, bb	MAC	MAC
DENTURE REPAIR					
Repair denture base	B	0	e, bb	MAC	MAC
Replace teeth - complete denture, per tooth	B	0	e, bb	MAC	MAC
Repair partial base	B	0	e, bb	MAC	MAC
Repair partial framework	B	0	e, bb	MAC	MAC
Repair or replace broken retentive/clasping material	B	0	e, bb	MAC	MAC
Replace broken teeth – partial per tooth	B	0	e, bb	MAC	MAC
Add tooth to existing partial	B	0	e, bb	MAC	MAC
Add clasp to existing partial	B	0	e, bb	MAC	MAC
Replace all teeth and acrylic on cast metal framework	E	0		MAC	MAC
Reline upper denture (chairside)	B	0	h, bb	MAC	MAC
Reline lower denture (chairside)	B	0	h, bb	MAC	MAC
Reline upper partial (chairside)	B	0	h, bb	MAC	MAC
Reline lower partial (chairside)	B	0	h, bb	MAC	MAC
Reline upper denture (lab)	B	0	h, bb	MAC	MAC

Covered procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
Reline lower denture (lab)	B	0	h, bb	MAC	MAC
Reline upper partial (lab)	B	0	h, bb	MAC	MAC
Reline lower partial (lab)	B	0	h, bb	MAC	MAC
Rebase complete denture – upper	B	0	h, bb	MAC	MAC
Rebase complete denture – lower	B	0	h, bb	MAC	MAC
Rebase partial denture – upper	B	0	h, bb	MAC	MAC
Rebase partial denture – lower	B	0	h, bb	MAC	MAC
Tissue conditioning – upper	B	0	k, bb	MAC	MAC
Tissue conditioning – lower	B	0	k, bb	MAC	MAC
Denture adjustment maxillary – upper	B	0	a, bb	MAC	MAC
Denture adjustment mandibular – lower	B	0	a, bb	MAC	MAC
Partial adjustment maxillary – upper	B	0	a, bb	MAC	MAC
Partial adjustment mandibular – lower	B	0	a, bb	MAC	MAC
ENDODONTICS					
Therapeutic pulpotomy	B	0	f	MAC	MAC
Pulpal debridement	E	0		MAC	MAC
Pulpal therapy – primary teeth	B	0	u	MAC	MAC
Retreatment of previous root canal	B	0	u	MAC	MAC
Apexification/recalcification	E	0		MAC	MAC
Root canal – anterior	B	0	u	MAC	MAC
Root canal – bicuspid	B	0	u	MAC	MAC
Root canal – molar	B	0	u	MAC	MAC
Apicoectomy – anterior	B	0	u	MAC	MAC
Apicoectomy – bicuspid	B	0	u	MAC	MAC
Apicoectomy – molar	B	0	u	MAC	MAC
Retrograde filling	B	0	u	MAC	MAC
Root amputation	B	0	u	MAC	MAC
Hemisection- including root removal, not including root canal therapy	E	0		MAC	MAC
PERIODONTICS (NON-SURGICAL)					
Scaling and root planing–per quadrant	B	0	n	MAC	MAC
Periodontal debridement (full mouth)	A	0	v	MAC	MAC
Periodontal maintenance procedure	B	0	ii	MAC	MAC
Localized delivery of antimicrobial agengs	B	0	o	MAC	MAC
PERIODONTICS (SURGICAL)					
Gingivectomy or gingivoplasty – per quadrant	B	0	n	MAC	MAC
Gingival flap procedure – per quadrant	B	0	n	MAC	MAC
Osseous surgery – per quadrant	B	0	n	MAC	MAC
Pedicle soft tissue grafts	B	0	n	MAC	MAC
Autogenous connective tissue grafts	B	0	n	MAC	MAC

Covered procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
Non-autogenous connective tissue grafts	B	0	n	MAC	MAC
Mesial/distal wedge, single tooth	E	0		MAC	MAC
Free soft tissue graft	B	0	n	MAC	MAC
Subepithelial connective tissue graft	B	0	n	MAC	MAC
Bone replacement graft	B	0	n	MAC	MAC
Tissue regeneration	B	0	n	MAC	MAC
CROWN, SINGLE RESTORATION					
Crown - resin-based composite (indirect)	E	0		MAC	MAC
Crown – ¾ resin-based composite (indirect; excluding facial veneers)	E	0		MAC	MAC
Crown - resin with high noble metal	C	0	l, t	MAC	MAC
Crown resin – resin with noble metal	C	0	l, t	MAC	MAC
Crown resin – resin with predominately base metal	C	0	l, t	MAC	MAC
Crown – porcelain/ceramic	C	0	l, t	MAC	MAC
Crown - porcelain fused to high noble metal	C	0	l, t	MAC	MAC
Crown – porcelain fused to noble metal	C	0	l, t	MAC	MAC
Crown –porcelain fused to predominantly base metal	C	0	l, t	MAC	MAC
Crown – ¾ cast high noble metal	C	0	l	MAC	MAC
Crown – ¾ case predominantly base metal	C	0	l	MAC	MAC
Crown – full cast high noble metal	C	0	l	MAC	MAC
Crown – full cast predominantly base metal	C	0	l	MAC	MAC
OTHER RESTORATIVE SERVICES					
Re-cement or re-bond indirectly fabricated or prefabricated post and core	B	0	u, bb	MAC	MAC
Prefabricated crown – porcelain/ceramic, primary anterier	B	0	l	MAC	MAC
Prefabricated crown - stainless steel, primary tooth	B	0	l	MAC	MAC
Prefabricated crown – stainless steel, permanent tooth	B	0	l	MAC	MAC
Crown lengthening – hard tissue	C	0	nn, u, v	MAC	MAC
Core build-up (including any pins)	C	0	l	MAC	MAC
Pin retention – per tooth, in addition to restoration	C	0	l	MAC	MAC
Post and core – in addition to crown, indirectly fabricated	C	0	l	MAC	MAC
Additional indirectly fabricated post	C	0	l	MAC	MAC

Covered procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
(same tooth)					
Prefabricated post and core – in addition to crown	C	0	I	MAC	MAC
Additional prefabricated post (same tooth)	C	0	I	MAC	MAC
Onlay, metallic	C	0	I	MAC	MAC
Onlay, resin-based composite	C	0	I	MAC	MAC
Onlay, porcelain/ceramic	C	0	I, t	MAC	MAC
Additional procedures to construct new crown under existing partial	E	0		MAC	MAC
BRIDGE, FIXED PARTIAL					
Pontic – indirect resin based composite	E	0		MAC	MAC
Pontic cast high noble metal	C	0	I	MAC	MAC
Pontic cast noble metal	C	0	I	MAC	MAC
Pontic cast predominantly base metal	C	0	I	MAC	MAC
Pontic- titanium and titanium alloys	E	0		MAC	MAC
Pontic- porcelain/ceramic	C	0	I, t	MAC	MAC
Pontic- porcelain fused to high noble metal	C	0	I, t	MAC	MAC
Pontic -porcelain fused to noble metal	C	0	I, t	MAC	MAC
Pontic- porcelain fused to predominantly base metal	C	0	I, t	MAC	MAC
Pontic - resin with high noble metal	C	0	I	MAC	MAC
Pontic - resin with noble metal	C	0	I	MAC	MAC
Pontic- resin with predominantly base metal	C	0	I	MAC	MAC
Retainer – cast metal	C	0	I	MAC	MAC
Retainer – porcelain/ceramic	C	0	I, t	MAC	MAC
Retainer crown- resin with high noble metal	C	0	I	MAC	MAC
Retainer crown- resin with noble metal	C	0	I	MAC	MAC
Retainer crown- resin with predominantly base metal	C	0	I	MAC	MAC
Retainer crown- porcelain / ceramic	C	0	I,t	MAC	MAC
Retainer crown- Porcelain fused to high noble metal	C	0	I,t	MAC	MAC
Retainer crown- porcelain fused to high noble metal	C	0	I,t	MAC	MAC
Retainer crown- porcelain fused to noble metal	C	0	I,t	MAC	MAC
Retainer crown - porcelain fused to predominantly base metal	C	0	I,t	MAC	MAC
Retainer crown - ¾ cast high noble metal	C	0	I	MAC	MAC
Retainer crown- full cast noble metal	C	0	I	MAC	MAC
Retainer crown- full cast predominantly base metal	C	0	I	MAC	MAC
Prefabricated post and core in addition to fixed partial denture	C	0	I	MAC	MAC

Covered procedures	Procedure Class*	Waiting Period (Months)	Limitation	Maximum Reimbursement	
				In-Network	Out-of-Network
retainer					
DENTURES					
Complete upper denture	C	0	l	MAC	MAC
Complete lower denture	C	0	l	MAC	MAC
Immediate upper denture	C	0	l	MAC	MAC
Immediate lower denture	C	0	l	MAC	MAC
Maxillary (upper) partial – resin base	C	0	l	MAC	MAC
Mandibular (lower) partial – resin base	C	0	l	MAC	MAC
Maxillary (upper)partial – cast metal framework with resin base	C	0	l	MAC	MAC
Mandibular (lower) partial – cast metal framework with resin base	C	0	l	MAC	MAC
Maxillary partial denture – flexible base	C	0	l	MAC	MAC
Mandibular partial denture – flexible base	C	0	l	MAC	MAC
Removable unilateral partial denture	C	0	l	MAC	MAC
IMPLANT SERVICES					
Abutment supported single crown	C	0	cc	MAC	MAC
Implant supported single crown	C	0	cc	MAC	MAC
Implant abutment	C	0	cc	MAC	MAC
ORTHODONTIA					
Limited orthodontic treatment	D	0	(p)(v)	MAC	MAC
Interceptive orthodontic treatment	D	0	(p)(v)	MAC	MAC
Comprehensive orthodontic treatment	D	0	(p)	MAC	MAC
Initial orthodontic examination	D	0	(p)(v)	MAC	MAC
Initial placement of braces or appliances	D	0	(p)(v)	MAC	MAC
Continuing treatment for braces or appliances including retention	D	0	(p)	MAC	MAC
Removable appliance therapy	E	0		MAC	MAC
Fixed appliance therapy	D	0	(p)	MAC	MAC
MISCELLANEOUS					
Endosteal implants	C	0	u, hh	MAC	MAC
TMJ treatment	E	0	gg	MAC	MAC
Occlusal guard	B	0	gg	MAC	MAC

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

A Mutual Company Incorporated in 1909
Madison, WI

AMENDMENT

The Policy and Certificate to which this Amendment is attached are amended as follows:

The NGL address in the "Underwritten by:" field on the cover page is hereby revised to remove the P.O. Box 1191, and related zip code, and is replaced with the NGL Home Office Address only, as follows:

Underwritten by:	National Guardian Life Insurance Company (called "We", "Our", and "Us") Two East Gilman Street Madison, WI 53703

All other terms of the Policy and Certificate remain the same. There is no change to the mailing address of Our Administrator for matters such as premium payment, administrative changes, claims, complaints, grievances or appeals for your coverage.

Please place this Amendment with Your Policy/Certificate.

This Amendment is effective as of the effective date of the Policy/Certificate January 1, 2023.

Kimberly A. Shaul, Secretary

Knut A. Olson, President

NOTICE OF PROTECTION PROVIDED BY
CALIFORNIA LIFE AND HEALTH INSURANCE GUARANTEE ASSOCIATION

This notice provides a brief summary regarding the protections provided to policyholders by the California Life and Health Insurance Guarantee Association ("the Association"). The purpose of the Association is to assure that policyholders will be protected, within certain limits, in the unlikely event that a member insurer of the Association becomes financially unable to meet its obligations. Insurance companies licensed in California to sell life insurance, health insurance, annuities and structured settlement annuities are members of the Association. The protection provided by the Association is not unlimited and is not a substitute for consumers' care in selecting insurers. This protection was created under California law, which determines who and what is covered and the amounts of coverage.

Below is a brief summary of the coverages, exclusions and limits provided by the Association. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations or the rights or obligations of the Association.

COVERAGE

- **Persons Covered**

Generally, an individual is covered by the Association if the insurer was a member of the Association *and* the individual lives in California at the time the insurer is determined by a court to be insolvent. Coverage is also provided to policy beneficiaries, payees or assignees, whether or not they live in California.

- **Amounts of Coverage**

The basic coverage protections provided by the Association are as follows:

- **Life Insurance, Annuities and Structured Settlement Annuities**

For life insurance policies, annuities and structured settlement annuities, the Association will provide the following:

- Life Insurance
  80% of death benefits but not to exceed $300,000
  80% of cash surrender or withdrawal values but not to exceed $100,000

- Annuities and Structured Settlement Annuities
  80% of the present value of annuity benefits, including net cash withdrawal and net cash surrender values but not to exceed $250,000

The maximum amount of protection provided by the Association to an individual, for *all* life insurance, annuities and structured settlement annuities is $300,000, regardless of the number of policies or contracts covering the individual.

- **Health Insurance**

The maximum amount of protection provided by the Association to an individual, as of July 1, 2016, is $546,741. This amount will increase or decrease based upon changes in the health care cost component of the consumer price index to the date on which an insurer becomes an insolvent insurer. Changes to this amount will be posted on the Association’s website www.califega.org.

COVERAGE LIMITATIONS AND EXCLUSIONS FROM COVERAGE

The Association may not provide coverage for this policy. Coverage by the Association generally requires residency in California. You should not rely on coverage by the Association in selecting an insurance company or in selecting an insurance policy.

The following policies and persons are among those that are excluded from Association coverage:

- A policy or contract issued by an insurer that was not authorized to do business in California when it issued the policy or contract.
- A policy issued by a health care service plan (HMO), a hospital or medical service organization, a charitable organization, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company, an insurance exchange, or a grants and annuities society.
- If the person is provided coverage by the guaranty association of another state.
- Unallocated annuity contracts; that is, contracts which are not issued to and owned by an individual and which do not guaranty annuity benefits to an individual.
- Employer and association plans, to the extent they are self-funded or uninsured.
- A policy or contract providing any health care benefits under Medicare Part C or Part D.
- An annuity issued by an organization that is only licensed to issue charitable gift annuities.
- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as certain investment elements of a variable life insurance policy or a variable annuity contract.
- Any policy of reinsurance unless an assumption certificate was issued.
- Interest rate yields (including implied yields) that exceed limits that are specified in Insurance Code Section 1607.02(b)(2)(C).

NOTICES

Insurance companies or their agents are required by law to give or send you this notice. Policyholders with additional questions should first contact their insurer or agent. To learn more about coverages provided by the Association, please visit the Association's website at www.califega.org, or contact either of the following:

California Life and Health Insurance
Guarantee Association
P. O. Box 16860,
Beverly Hills, CA 90209-3319
(323) 782-0182

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street
Los Angeles, CA 90013
(800) 927-4357

Insurance companies and agents are not allowed by California law to use the existence of the Association or its coverage to solicit, induce or encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and California law, then California law will control.

KEEP THIS NOTICE WITH YOUR INSURANCE PAPERS

PROBLEMS WITH YOUR INSURANCE? If you are having problems with your insurance company or agent, do not hesitate to contact the insurance company or agent to resolve your problem.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
c/o Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, Ohio 45275
1-800-648-1179

You should always contact the Company or agent first. If your discussions with the insurer or agent fail to provide a satisfactory resolution to your problem or concern, you may then contact the California Department of Insurance, Consumer Communications Bureau.

You can contact the **Consumer Communications Bureau** by:

Visiting their website at: www.insurance.ca.gov

Writing to:

California Department of Insurance
Consumer Communications Bureau
300 South Spring Street, South Tower
Los Angeles, CA 90013

Calling:

1-800-927-Help (4357) or
1-213-897-8921

TDD Number
1-800-482-4TDD (4833)

Form 2356-CA 04/18

Appendix A

Privacy Information for California Residents

Effective Date: June 1, 2020

This Appendix discusses how National Guardian Life Insurance Company ("we," "us," or "our") collects personal information of California residents. This Appendix applies solely to individuals who reside in the State of California ("consumers" or "you"). This Appendix complies with the California Consumer Privacy Act of 2018 ("CCPA") and any terms defined in the CCPA have the same meaning when used in this Appendix. This Appendix does not apply to personal information outside the scope of the CCPA, including without limitation:

- Personal information collected, processed, sold, or disclosed pursuant to the Gramm-Leach-Bliley Act, and implementing regulations, or the California Financial Information Privacy Act.

- Personal information bearing on a consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living as set forth in the Fair Credit Reporting Act.

- Personal health information collected, processed, or disclosed pursuant to the Health Insurance Portability and Accountability Act.

1. *National Guardian Life Insurance Company as a Service Provider*

When we act as a service provider for our customers, we collect personal information on behalf of our customers subject to our contractual obligations. When we act as a service provider, we follow the instructions of our customer on how to process personal information on our customer's behalf. The provisions of this Appendix do not apply to the personal information that we process on behalf of our business customers.

2. *What Personal Information We Collect and How We Share it*

The below chart lists the categories of personal information that we may collect and have collected in the past 12 months and how we share such information. We will share personal information with parties to whom you have directed or authorized us to share with.

Categories of Personal Information	Categories of Service Providers and Third Parties with whom Personal Information is Shared
Identifiers. This may include a real name, alias, address, email address, phone number, Social Security Number, driver's license number, online identifier, IP address, account username and password, job title, or other similar identifiers.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; data analytics providers; prospective purchasers of our business; and outside auditors and lawyers.

Internet and network information. This may include information on your interaction with a website, application, or advertisement, such as browsing history and how you use your account.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; and data analytics providers.
Device information. This may include the operating system of your device, device identifier, the type of device you are using, or your geolocation information.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; and data analytics providers.
Other information you submit to us. This may include requests or communications you submit to us, including emails, ratings, or customer service call recording.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; prospective purchasers of our business; and outside auditors and lawyers.
Research or survey information. This may include survey results, social media data, and other information about your participation in consumer research.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; prospective purchasers of our business; and outside auditors and lawyers.
Inferences we draw about you. This may include information about your preferences, characteristics, predispositions, behavior, or other trends that help us identify which products you may be interested in.	Entities that we are required to share with pursuant to law or for legal proceedings; service providers; our affiliates and business partners; and data analytics providers.

3. *How We Use Personal Information*

We may use personal information in the following ways:

- To provide you with information, products, or services;
- To improve our services and products;
- To secure and monitor our websites;
- For audit or research purposes;
- To resolve grievances;
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue;
- To respond to requests from law enforcement or other government authorities as required by law; or
- For our own legal obligations and business needs.

4. *Sale of Personal Information*

CCPA defines a "sale" of personal information broadly to include more than exchanges for monetary purposes. A sale can include personal information shared with a third party for "valuable consideration," or information shared with a third party (even if they are performing services on our behalf) if they are permitted to use the information for their own purposes.

We do not and have not sold any personal information in the previous 12 months.

5. *California Residents' Rights and Choices*

The CCPA provides California residents with specific rights regarding their personal information, described below. Below are your CCPA rights and how to exercise those rights.

a. *Access to Specific Information and Data Portability Rights ("Right to Know")*

You have the right to request that we disclose certain information to you about our collection and use of your personal information over the past 12 months. You could request:

- The categories of personal information we collected about you;
- The categories of sources of the personal information we collected about you;
- Our business or commercial purpose for collecting that personal information;
- The categories of third parties with whom we share that personal information; or
- The specific pieces of personal information we collected about you.

Our employees and employees of our business partners and service providers also do not have a Right to Know.

b. *Deletion Request Rights ("Right to Deletion")*

You have the right to request that we delete some or all of the personal information that we have collected from you and retained, subject to a number of exceptions. We are not required to delete personal information that is: (a) necessary to complete a transaction with you or for warranty or product recalls; (b) used for security purposes, to prevent fraud, to fix errors, or to comply with law; (c) reasonable for us to use for internal purposes given our relationship with you; or (d) compatible with the context in which you provided the information. The list of exceptions above is not exhaustive, and we may also deny a deletion request as otherwise permitted by law.

Our employees and employees of our business partners and service providers do not have a Right to Deletion.

c. *Exercising Your Rights*

To exercise your rights described above, please submit a verifiable consumer request to us by either:

- Calling us at 800-548-2962.
- Request a form to be completed by writing to us at:

  National Guardian Life Insurance Company
  PO Box 1191
  Madison, WI 53701

Only you, or a person or entity that you authorize to act on your behalf, may make a verifiable consumer request related to your personal information. You may also make a verifiable consumer request on behalf of your minor child. If you are making a request on behalf of another person, you must provide written legal documentation that you are authorized to act on behalf of that individual.

You may only make a verifiable consumer request for access or data portability twice within a 12-month period. The verifiable consumer request must:

- Provide sufficient information that allows us to reasonably verify you are the person about whom we collected personal information or an authorized representative; and
- Describe your request with sufficient detail that allows us to properly understand, evaluate, and respond to it.

We may not be able to fulfill your request or provide you with personal information if we cannot verify your identity or authority to make the request and confirm the personal information relates to you. To verify your identity, we may request up to three pieces of personal information about you, and we reserve the right to take additional steps, as necessary, to verify your identity if we have reason to believe a request is fraudulent.

d. *Response Timing and Format*

We endeavor to respond to a verifiable consumer request within 45 days of its receipt. If we require more time (up to 90 days), we will inform you of the reason and extension period in writing.

Any disclosures we provide will only cover the 12-month period preceding the date we received your verifiable consumer request. The response we provide will also explain the reasons we cannot comply with a request, if applicable. For data portability requests, we will select a format to provide your personal information that is readily useable and should allow you to transmit the information from one entity to another entity without hindrance.

We do not charge a fee to process or respond to your verifiable consumer request unless it is excessive, repetitive, or manifestly unfounded. If we determine that the request warrants a fee, we will tell you why we made that decision and provide you with a cost estimate before completing your request.

e. *Non-Discrimination*

You have the right to not be discriminated against for exercising any of your CCPA rights. Unless permitted by the CCPA, we will not:

- Deny you goods or services;
- Charge you different prices or rates for goods or services, including through granting discounts or other benefits, or imposing penalties;
- Provide you a different level or quality of goods or services; or

- Suggest that you may receive a different price or rate for goods or services or a different level or quality of goods or services.

6. Other California Privacy Rights

California's "Shine the Light" law (Civil Code Section § 1798.83) permits users of our Website that are California residents to request certain information regarding our disclosure of personal information to third parties for their direct marketing purposes. To make such a request, please contact us through the information provided above.

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Beam Insurance Administrators, LLC and National Guardian Life Insurance Company are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How We May Use or Disclose Your Health Information

1. Payment Functions. We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. Health Care Operations. We may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. Required by Law. As required by law, we may use and disclose your health information. We may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. Public Health. As required by law, we may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. Coroners, Medical Examiners and Funeral Directors. We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. Organ and Tissue Donation. Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. Health and Safety. We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. Government Functions. We may disclose your health information for military, national security, prisoner and government benefits purposes.

9. Worker's Compensation. We may disclose your health information as necessary to comply with worker's compensation or similar laws.

10. Disclosures to Plan Sponsors. We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. Right to Request Restrictions. You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, we may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that we amend your health information. We are not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. We will provide one list per 12 month period free of charge; we may charge you for any additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Our Obligations Under This Notice

We are required by law to:

1. Maintain the privacy of your health information.

2. Provide you with a notice of our legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.

4. Provide you notice of a breach of any unsecured personal health information.

5. Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.

6. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

7. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law, including psychotherapy notes, personal health information for marketing purposes, and information in instances constituting the sale of personal health information.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. Revised Notices will be distributed to you by mail.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Beam Insurance Administrators LLC
PO Box 75372
Cincinnati, OH 45275

You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Effective Date of This Notice: April 25, 2016.

Privacy Notice

Why We Collect and How We Use Information:
When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:
We collect most information directly from you on applications or from other communications with you during the application process.
Types of Information we could collect include, but not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics
- phone number
- email

We also may keep information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- Other insurance companies
- agents
- employers
- public records
- consumer reporting agencies
- service providers
- Google analytics
- website hosts

How We Disclose Your Information:
Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL's website, **www.nglic.com.**