CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004

The group dental expense coverage described in this Certificate is attached to the group Policy effective January 1, 2015. This Certificate replaces any Certificate previously issued under the Plan or under any other Plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP DENTAL EXPENSE COVERAGE
INCLUDING PEDIATRIC DENTIAL ESSENTIAL HEALTH BENEFIT SERVICES

Guardian certifies that the Employee named below is entitled to the benefits provided by Guardian described in this Certificate. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; and (b) all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown on Our and/or the Policyholder's records.

Policyholder:	Group Policy Number:
Issued To:	
Certificate Number:	Effective Date:

Policyholder: RI-SUPPLEMENT PLAN

Group Policy Number: 00494953

The Guardian Life Insurance Company of America

Raymond J McNamara

Vice President, Group Product

B951.0055

GC-SUPP-SHOP-15-RI

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DEFINITIONS

This section defines certain terms appearing in Your Certificate.

Anterior Teeth: This term means the incisor and cuspid teeth. These are the teeth located in front of the bicuspids (pre-molars).

Appliance: This term means any dental device other than a Dental Prosthesis.

Benefit Year: This term means a 12 month period which starts on January 1 and ends on December 31.

Covered Dental Specialty: This term means any group of procedures which falls under one of the following categories, whether performed by a specialist Dentist or a general Dentist: (1) restorative/prosthodontic services; (2) endodontic services; (3) periodontic services; (4) oral surgery; and (5) pedodontics.

Covered Family: This term means You and those of Your dependents who are covered by this Plan.

Covered Person: This term means You, if You are covered by this Plan, and any of Your covered dependents.

Dental Necessity: This term means dental care services that are appropriate, in terms of type, amount, frequency, level, setting and duration to the covered person's diagnosis or conditions and that must be informed by generally accepted dental evidence consistent with generally accepted dental practice parameters.

Dental Prosthesis: This term means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of: (1) abutment crowns; (2) inlays and onlays; (3) bridge pontics; (4) complete and immediate dentures; (5), partial dentures; and (6) unilateral partials. It also includes all types of: (a) crowns; (b) veneers; (c) implants; and (d) posts and cores.

Dentist: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Plan.

Eligibility Date: For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan.

Emergency Treatment: This term means bona fide emergency services which: (1) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort or to prevent the imminent loss of teeth; and (2) are covered by this Plan.

Employee: This term means a person who works no less than 20 hours per week for the Employer and whose income is reported for tax purposes using a W-2 form.

Employer: This term means RI-SUPPLEMENT PLAN .

Injury: This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Plan; and (2) all complications arising from that damage. But, the term does not include damage to teeth, Appliances or dental prostheses which results solely from chewing or biting food or other substances.

Late Entrant: This term means a person who: (1) becomes covered by this Plan more than 31 days after he or she is eligible; or (2) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

Non-Preferred Provider: This term means a Dentist or dental care facility that is not under contract with DentalGuard Preferred as a Preferred Provider.

Orthodontic Treatment: This term means the movement of one or more teeth by the use of Active Appliances. It includes: (1) treatment plan and records, including initial, interim and final records; (2) periodic visits; (3) limited Orthodontic Treatment, interceptive Orthodontic Treatment and comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances; and (4) orthodontic retention, including any and all necessary fixed and removable Appliances and related visits.

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Payment Limit: This term means the maximum amount this Plan pays for covered charges for covered services during a Benefit Year.

Payment Rate: This term means the percentage rate that this Plan pays for covered charges for covered services.

Plan: This term means the group dental expense coverage described in the Policy and this Certificate.

Posterior Teeth: This term means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

Preferred Provider: This term means a Dentist or dental care facility that is under contract with DentalGuard Preferred as a Preferred Provider.

Proof of Claim: This term means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

Qualified Retiree: This term means an Employee who retires and is considered a Covered Person under this Plan.

Rollover: This term means the dollar amount which will be added to a Covered Person's Rollover Account when he or she receives benefits in a Benefit Year that do not exceed the Rollover Threshold.

Rollover Account: This term means the amount of a Covered Person's accrued Rollover.

Rollover Account Maximum: This term means the maximum amount of Rollover that a Covered Person can store in his or her Rollover Account.

Rollover Threshold: This term means the maximum amount of benefits that a Covered Person can receive during a Benefit Year and still be entitled to receive a Rollover.

Service Payment Limit: This term means the maximum amount this Plan pays for covered charges for a particular covered service each time it is performed. The services We cover and the Service Payment Limit for each service are shown in this Plan's List of Covered Dental Services.

We, Us, Our and Guardian: These terms mean The Guardian Life Insurance Company of America.

You or Your: These terms mean the insured Employee.

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GC-SUPP-SHOP-15-RI

GENERAL PROVISIONS

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

Incontestability

The Plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except in the case of fraud or intentional misrepresentation of material fact, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred, after such insurance has been in force for two years during his or her lifetime.

If the Plan replaces a plan Your Employer had with another insurer, We may rescind the Plan based on misrepresentations made by the Employer or an Employee signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to fraud or intentional misrepresentation of material fact made in Your application, We will send 30 days prior written notice to You. That notice and the premium paid by You for the periods such insurance is void and will be sent to Your last known address on file with Your Employer or US.

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DENTAL CLAIMS PROVISIONS

Your right to make a claim for dental benefits provided by the Policy is governed as shown below.

Notice

You must send Us written notice of an Injury or sickness for which a claim is being made within 20 days of the date the Injury occurs or the sickness starts. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

Claim Forms

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the Injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

Proof of Loss

You must send written proof to Our designated office within 90 days of the loss.

Late Notice of Proof

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

Payment of Benefits

We will pay all dental benefits when We receive written proof of loss.

Unless otherwise required by law or regulation, We pay all dental benefits to You. If You are not living, We have the right to pay all dental benefits to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

When proof of loss is filed, You or any other payee may direct Us, in writing, to pay dental benefits to the Provider who furnished the covered service for which benefits became payable. However, We cannot require that a particular provider furnish such care. You or any other payee may not assign the right to take legal action under the Policy to such provider.

Legal Actions

No legal action against the Policy shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against the Policy after three years from the date written proof of loss is required to be given.

Workers' Compensation

The dental benefits provided by the Policy are not in place of, and do not affect requirements for, coverage by Workers' Compensation.

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UTILIZATION REVIEW PROCESS

Utilization Review Determinations: All information necessary to conduct a review must be provided. If the covered person or provider does not release the required information, certification or coverage for a procedure or service may be denied. The utilization review criteria for proposed or delivered health care services will be provided at the request of the covered person or provider.

Pre-Service Claims: The Covered person and provider will be notified of the initial determination no later than 15 business days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Concurrent review: The covered person and provider will be notified of the initial determination before end of the course of treatment. But when a covered person is held financially harmless, the covered person and provider will be notified within one business day of the determination. And, if provider whose input is essential has not been reasonably available, notice may be delayed one business day in order to attempt further contact with that provider.

Retrospective review: A retrospective adverse determination will be sent to the covered person and provider within 15 business days of receipt of a request for payment that includes all supporting documentation for the benefit being reviewed.
Coverage for services that received prior approval cannot be denied retrospectively unless: (a) the approval was based on inaccurate information material to the review; or (b) the services were not consistent with: (i) a submitted plan of care; and/or (ii) any restrictions included in the prior approval.

Notice of Adverse Determination: Written notice of a concurrent adverse determination or of any adverse determination for emergency care services will include: (a) the principal reason(s) for the determination; (b) instructions for initiating an appeal, including the time period during which an appeal must be filed; and (c) the telephone number of the person to contact in regard to an appeal.
Written notice of a retrospective adverse determination for non-emergency care will include: (a) documentation that the determination was based on the medical necessity and/or appropriateness of the health care service; and (b) the telephone number of the person to contact in regard to an appeal.

Emergency Care Services: We cover services that treat or stabilize an emergency condition, including out-of-state/area emergencies. Such services will include: (a) a screening to determine if an emergency exists; (b) treatment to stabilize the condition so that there will be no further material deterioration; and (c) medically necessary post stabilization covered services. Coverage is subject to co-payments, coinsurance and deductibles, if applicable.

Urgent Health Care Services: We cover services rendered by a provider to treat an urgent health care condition within 24 hours of the request for such services. Coverage is subject to co-payments, coinsurance and deductibles, if applicable. **Note:** In cases where a covered person or provider demonstrates that a timely response is urgent, a verbal request for the results of the initial utilization review determination will be accepted. The verbal request must be forwarded in writing within 7 days.

Utilization Review Appeals: If the covered person or his or her provider does not agree with the outcome of a utilization review, he or she or the provider may initiate an appeal.

Levels of Appeals: This plan has: (a) an internal appeals process; (b) an external appeals process; and (c) an expedited appeals process.

At each utilization review appeal level, all necessary information for the review must be provided. Any added information that relates to the case and impacts an adverse decision will be considered in the review. Directions for each appeal level are shown below.

Internal Appeals

First Level Appeals: If a covered person or provider does not agree or is not satisfied with an initial adverse determination, he or she or the provider has the right to request a first level appeal.

The request for a first level appeal must be filed within 60 days of the date of the notice of the adverse determination.

To start the appeal, the covered person or provider must submit the request in writing as directed below. However, if emergency or urgent health care services are involved, the covered person or provider may request a review by calling the appropriate toll-free number shown below.

The request for an appeal of an adverse determination for dental coverage should be made to:

The Guardian Life Insurance Company of America
Group Quality Assurance -WRO P.O. Box 2457
Spokane, WA 99210-2457
Telephone: (800) 541-7846

Pre-Service Claims: Guardian will notify the claimant of its decision not later than 15 business days after receipt of the request for review of the adverse determination.

Concurrent Claims: Guardian will notify the claimant of its decision not later than 15 business days after receipt of the request for review of the adverse determination.

Post-Service Claims: Guardian will notify the claimant of its decision not later than 15 business days after receipt of the request for review of the adverse determination.

But, if verbal notice is given to the covered person and provider within these required time frames, written notice of the decision may be given within 6 business days following the verbal notice.

If the first level appeals decision upholds the adverse determination, the written notice will include: (a) the reasons the denial is being upheld; and (b) the right to make a second level appeal and how and to whom it must be made.

Second Level Appeals: If the covered person or provider does not agree or is not satisfied with the outcome of the first level appeal, as directed he or she or the provider may request a second level appeal.

Prior to the final second level appeal decision, the covered person or provider will be offered an opportunity to inspect the utilization review file and to add information to this file in writing.

Pre-Service Claims: Guardian will notify the claimant of its decision not later than 15 business days after receipt of the request for review of the adverse determination.

Concurrent Claims: Guardian will notify the claimant of its decision not later than 15 business days after receipt of the request for review of the adverse determination.

Post-Service Claims: Guardian will notify the claimant of its decision not later than 15 business days after receipt of the request for review of the adverse determination.

But, if verbal notice is given to the covered person and provider within the required time frames, written notice of the decision may be given within 6 business days following the verbal notice.

If the second level appeal is not successful, the written notice of the decision will include: (a) notice that the decision may be appealed to a state designated external appeals agency; (b) the means by which such an external appeal may be initiated; and (c) the fee for completing such an external appeal.

Expedited Appeals/Urgent Care Claims: At the first or second internal appea level, when an emergency condition exists and emergency care services are required, a covered person or provider may make an oral or written request for a expedited appeal.

For an expedited appeal, a decision will be reached within two business days of the date the appeal is filed, provided all information necessary to complete the appeal was received. The covered person and provider will be notified of the decision.

External Appeals

The Covered Person or provider may file a written request with Us for an external appeal review of Our appeal resolution. An external appeal also may be requested due to Our decision to rescind this Certificate even if there is no adverse effect on any benefit.

We will bear all costs associated with an external appeal. Such request must be made not more than one hundred twenty (120) days after We notify the Covered Person of Our appeal resolution. We will provide the Covered Person with:

1.An expedited external review for an appeal related to an illness, a disease, a condition, an injury, or a disability if the time frame for a standard review would seriously jeopardize the Covered Person's: (1) life or health; or (2) ability to reach maintain maximum function; or
2.A standard external appeal review for an appeal not described above under expedited external review.

Independent Review Organizations
When the Covered Person files a request for an expedited external review, We will:

1.Refer the external review to an independent review agency, which is designated by Rhode Island s Director of Health.
2.The independent review organization chosen will assign a medical review professional who is board certified in the applicable specialty for resolution of an external appeal.
3.The independent review organization and the medical review professional conducting the external review may not have a material professional, familial, financial, or other affiliation with any of the following:
a.Us;
b.Any of Our officers, directors, or management employees;
c.The health care provider or the health care provider's medical group that is proposing the service;
d.The facility at which the service would be provided;
e.The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed for use by the treating health care provider; or
f.The Covered Person requesting the external appeal review.

However, the medical review professional may have an affiliation:

1.Under which the medical review professional provides health care services to Covered Persons provided under this Certificate; and
2.That is limited to staff privileges at the health facility, if the affiliation is disclosed to the Covered Person and Us before commencing the review, and neither the Covered Person nor We object.

The Covered Person will not pay any of the costs associated with the services of an independent review organization provided under this provision. All costs will be paid by Us.

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Rights and Duties
The Covered Person who files an external appeal:

1.Will not be subject to retaliation for exercising the Covered Person's right to an external appeal under this Certificate;
2.Will be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
3.Will be permitted to submit additional information relating to the proposed service throughout the review process; and
4.Must cooperate with the independent review organization by:
a.Providing any requested medical information; or
b.Authorizing the release of necessary medical information.

We will cooperate with an independent review organization selected as provided above under the Independent Review Organization provision by promptly providing any information requested by the independent review organization.

1.**Determinations by Review Organizations:** An independent review organization will make a determination to uphold or reverse Our appeal resolution based on information gathered from: (1) the Covered Person or the Covered Person's designee; (2) Us; (3) the treating health care provider; and (4) any additional information that the independent review organization considers necessary and appropriate.

When making the determination, the independent review organization will apply:
1.Standards of decision making that are based on objective clinical evidence; and
2.The terms of this Certificate.

In an external appeal, We bear the burden of proving that We properly denied coverage for a condition, complication, service, or treatment because the condition, complication, service, or treatment is directly related to a condition for which coverage has been waived.

The independent review organization will notify Us and the Covered Person of its determination:
1.For an expedited external appeal filed by a Covered Person, within 2 business days after making the determination; and
2.For a standard external appeal filed by a Covered Person, within 10 business days after making the determination.

The determination made by the independent review organization will be binding on Us.

Complaint Process

If the covered person is not satisfied with the quality of care provided by a preferred provider or any other action by a preferred provider in regard to managing the delivery of services, he or she may call or write to:

Guardian Compliance
The Guardian Life Insurance Company of America
7 Hanover Square Mail Station H23N
New York, NY 10004-2616
Telephone Number (212) 598-1384

After an initial analysis, the complaint will be forwarded to the appropriate area for review and response. Receipt of the complaint will be acknowledged in writing.

The complaint will be investigated and reviewed and a decision reached as to how it will be settled.

A written explanation of how the complaint was resolved will be sent to the covered person. The covered person will be advised that he or she contact the Rhode Island Department of Health if not satisfied with the resolution of the complaint.

Note: This dental plan is not capitated and does not contain other risk sharing arrangements.

You may also contact the Office of the Health Insurance Commissioner s Consumer Resource Program, RIREACH, for assistance at *1-855-747-3224 (855- RIREACH)* .

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ELIGIBILITY FOR DENTAL COVERAGE

Eligible Employee

Subject to the conditions of eligibility set forth below, and all of the other conditions of this Plan, You are an eligible Employee if:

- You have been deemed eligible by Your Employer; and
- Your Employer's eligibility standards are consistent with Rhode Island's Health Benefit Exchange (HealthSource RI) rules. HealthSource RI is able to determine Your eligibility and termination under this plan when You purchase this coverage on the Exchange.

Conditions of Eligibility

Enrollment Requirement: We will not cover You until You enroll then in this Plan and You agree to make the required payments.

Multiple Employment: If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple dental coverage under this Plan.

When Employee Coverage Starts

The date Your coverage is scheduled to start is shown on the face page of this Certificate of Coverage. You must elect to enroll and agree to make the required payments before Your coverage will start.

When Employee Coverage Ends

Your coverage will end on the first of the following dates:

- The day You stop being an eligible employee as defined by Your Employer.
- The last day of the period for which required payments are made for this Plan.

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DEPENDENT COVERAGE

Eligible Dependents for Dental Expense Coverage

Your eligible dependents are Your: (a) spouse and; (b) Your dependent children who are under age 26. Partners in a Civil Union will be treated equal to a spouse and in accordance with Rhode Island statutes.

Adopted Children and Step-Children

Your "dependent children" include Your legally adopted children and Your step-children. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. Eligibility for Dependent Children is not limited based on financial dependency of the Employee, residency, student status, employment, eligibility for other coverage or marital status neither can the terms of coverage vary based on the age of the Dependent Children.

Dependents Not Eligible

We exclude any dependent who is on active duty in any armed force. And We exclude any dependent who is covered by this Plan as an Employee.

A child may be an eligible dependent of more than one Employee who is covered under this Plan. In that case, the child may be covered for dependent dental care benefits by only one Employee at a time.

Handicapped Children

You may have a child: (a) with a mental or physical handicap or developmental disability and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent dental benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she is unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon You for most of his or her support and maintenance.
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

The child's coverage ends when Your coverage ends.

Waiver of Dental Late Entrant Penalty

If You initially waived dental coverage for Your dependents under this Plan because they were covered under another group dental plan and You now elect to enroll them in the dental coverage under this Plan, they will not be considered Late Entrants if their dental coverage under the other plan ends due to one of the events listed below:

- Termination of Your spouse's employment.
- Loss of eligibility under Your spouse's dental plan.
- Divorce.
- Death of Your spouse.
- Termination of the other dental plan.
- Any other event as required by state or federal law or in accordance with Your Employer's rules.

But, You must enroll Your dependents in the dental coverage under this Plan within 30 days of the date that any of the events listed above occurs.

And, Your dependents will not be considered Late Entrants if: (1) You are under legal obligation to provide dental coverage due to a court order; and (2) You enroll them in this Plan within 30 days of the issuance of the court order.

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When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time. The date Your dependent coverage is scheduled to start is shown on the face page of this Certificate of Coverage.

Exception: We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to carry out the normal activities of someone of like age and sex. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she resumes the normal activities of someone of like age and sex.

Newborn Children: We cover Your newborn child for dependent benefits from the moment of birth if: (1) You are already covered for dependent child coverage when the child is born; or (2) You enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If You fail to do this, once the child is enrolled, he or she: (a) is a Late Entrant; (b) is subject to any applicable Late Entrant penalties; and (c) will be covered as of the enrollment date.

When Dependent Coverage Ends

Dependent coverage for your Spouse ends on the last day of the month when:

- Your Employee coverage ends.
- Your marriage ends in legal divorce or annulment.

Dependent coverage for your dependent children ends on the last day of the month when:

- Your Employee coverage ends.
- He or she stops being an eligible dependent.
- He or she attains the age limit.
- Your handicapped child reaches the age limit, when he or she marries or is no longer dependent on You for support and maintenance.

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DENTAL EXPENSE BENEFITS

This coverage will pay many of a Covered Person's Group dental expenses. We pay benefits for covered charges incurred by a Covered Person. What We pay and terms for payment are explained below.

This Certificate includes form(s)SG-D-SOB-3-2015-GUARD, which is the Plan's Schedule of Benefits.

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This Plan is designed to provide high quality dental care while controlling the cost of such care. To do this, this Plan encourages a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian's dental preferred provider organizations (PPOs), which is called DentalGuard Preferred.

The dental PPO is made up of Preferred Providers in a Covered Person's geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Plan, You and Your covered dependents receive: (1) a dental plan ID card; and (2) information about current Preferred Providers.

This Plan usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider.

But, this Plan's Payment Limits differ based upon whether a Covered Person uses the services of a Preferred Provider or a Non-Preferred Provider. A Covered Person will usually be left with less out-of-pocket expense when a Preferred Provider is used.

A Covered Person must present his or her ID card when he or she uses a Preferred Provider. Most Preferred Providers prepare necessary claim forms for the Covered Person, and submit the forms to Us. We send the Covered Person an explanation of this Plan's benefit payments. But, any benefit payable by Us is sent directly to the Preferred Provider.

What We pay is based on all of the terms of this Plan. Please read this Plan carefully for specific benefit levels, deductibles Payment Rates and service Payment Limits.

A Covered Person may call Guardian at the number shown on his or her ID card should he or she have any questions about this Plan.

Covered Charges

Whether a Covered Person uses the services of a Preferred Provider or a Non-Preferred Provider, covered charges are the charges listed in the fee schedule the Preferred Provider has agreed to accept as payment in full, for the dental services listed in this Plan's List of Covered Dental Services.

To be covered by this Plan, a service must be: (1) necessary; (2) appropriate for a given condition; and (3) included in the List of Covered Dental Services.

We may use the professional review of a Dentist to determine the appropriate benefit for a dental procedure or course of treatment.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed: (1) prior to; (2) at the same time; or (3) at a later date. For benefit purposes under this Plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the Dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedures scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, We will only pay benefits for the osseous surgery.

We will not limit coverage based on genetic information, adjust premiums based on genetic information, nor will We require genetic testing or collect genetic information for underwriting purposes.

We only pay benefits for covered charges incurred while a person is covered by this Plan.

A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is first prepared. A covered charge for any other Dental Prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened.

All other covered charges are incurred on the date the services are furnished.

B951.2715

Alternate Treatment

If more than one type of service can be used to treat a dental condition, We have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by Us. For example, in the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

In an emergency, if a participating provider is not available within twenty-four (24) hours of an enrollees request or on the same day, if medically indicated, and the enrollee has no option but to receive covered emergency treatment from a non-participating provider, upon written notification to, and verification of the circumstances by, Guardian, the claim for such covered emergency treatment will be reimbursed at the in- network rate. Reimbursement at the in-network rate for such covered emergency treatment by a non-participating provider will be limited to only those covered dental procedures that are needed for the relief of acute pain, acute swelling, or treatment of trauma.

Proof of Claim

The Covered Person or his or her Dentist must provide Us with proof that is acceptable to Us. This proof may, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document Proof of Claim and support the necessity of the proposed treatment. If We do not receive the necessary proof, We may pay no benefits, or minimum benefits. But, if We receive the necessary proof within 15 months of the date of service, We will redetermine the Covered Persons benefits based on the new proof.

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the Covered Person's Dentist should send Us a treatment plan before he or she starts. This must be done on a form acceptable to Us. The treatment plan must include: (1) a list of the services to be done, using the American Dental Association Nomenclature and codes; (2) the itemized cost of each service; and (3) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to Us.

We review the treatment plan and estimate what We will pay. We will send the estimate to the Covered Person and his or her Dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to Us, We have the right to base Our benefit payments on treatment appropriate to the Covered Person's condition using accepted standards of dental practice.

The Covered Person and his or her Dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what We will pay. It tells the Covered Person, and his or her Dentist, in advance, what We would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (1) the services being performed as proposed and while the person is covered; and (2) the benefit provisions, and all of the other terms of this Plan.

Emergency Treatment, oral exams, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We will not deny or reduce benefits if pre-treatment review is not done. But, what We pay will be based on the availability and submission of Proof of Claim.

Benefits from Other Sources

Other plans may furnish benefits similar to the benefits provided by this Plan. For instance, You may be covered by this Plan and a similar plan through Your spouse's employer. You may also be covered by this Plan and a medical plan. In such instances, We coordinate Our benefits with the benefits from that other plan. We do this so that no one gets more in benefits than the charges he or she incurs. Read Coordination of Benefits to see how this works.

B951.0111

Waiting Periods for Certain Services

During the first 12 months a person is covered by this Plan, We will not cover charges for the following services:

- Group III Services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

This provision does not apply to Late Entrants. See Penalty for Late Entrants for details on what charges are not covered if a person is a Late Entrant.

This provision does not apply to the Pediatric Dental Services portion of this Plan.

The Waiting Period will be waived with proof of 12 consecutive months of prior group coverage with no lapse in coverage.

B951.0065

Penalty for Late Entrants

During the first six months that a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group II Services.

During the first 12 months that a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group III Services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

We do not apply a Late Entrant penalty to covered charges incurred for services needed solely due to an Injury suffered by a person while covered by this Plan.

We do not apply a Late Entrant penalty to the Pediatric Dental Services portion of this Plan.

B951.0067

Deductible: The Benefit Year deductible is shown in the Schedule of Benefits. Each Covered Person must have covered charges which exceed the deductible before We pay him or her any benefits for such charges. These charges must be incurred while he or she is covered.

Payment of Benefits: Once the deductible is met, We pay benefits for covered charges above that amount at the applicable Payment Rates for the rest of that Benefit Year. This Plan's Payment Rates are shown in the Schedule of Benefits.

After This Coverage Ends: We do not pay for charges incurred after a person's coverage ends.

B951.0069

Rollover of Benefit Year Payment Limit

A Covered Person will be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit, as follows:

If a Covered Person submits at least one claim for covered charges 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 Rollover Threshold, he or she will be entitled to a Rollover, subject to all of the conditions described below.

Note: If all of the benefits that a Covered Person Receives in a Benefit Year are for services provided by a Preferred Provider, he or she will be entitled to a greater Rollover than if any of the benefits are for services of a Non-Preferred Provider.

Rollovers can accrue and are stored in the Covered Person's Rollover Account. If a Covered Person reaches his or her Benefit Year Payment limit for Group I, II and III Services, we pay benefits up to the amount stored in the Covered Person's Rollover Account. The amount stored in the Rollover Account cannot be greater than the Rollover Account Maximum.

A Covered Person's Rollover Account will be eliminated, and the accrued Rollover lost, if he or she has a break in coverage of any length of time, for any reason; or if the Covered person does not submit a claim for covered charges during a Benefit Year.

The amounts of this Plan's Rollover Threshold, Rollover, and Rollover Account Maximum are:

- **Rollover Threshold** $700.00
- **Rollover** (if all benefits are for services provided by a Preferred Provider) $500.00
- **Rollover** (if any benefits are for services provided by a Non-Preferred Provider) $350.00
- **Rollover Account Maximum** $1,250.00

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If this Plan's dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full Benefit Year. And, if the effective date of a Covered Person's dental coverage is in October, November or December, this rollover provision will not apply to the Covered Person until January 1 of the next full Benefit Year. In either case: (1) only claims incurred on or after January 1 of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

If this Plan's dental coverage first becomes effective in the three months prior to the first full Benefit Year, this rollover provision will not apply until the first day of the first full Benefit Year. And, if the effective date of a Covered Person's dental coverage is within the three months prior to the start of this Plan's next Benefit Year, this rollover provision will not apply to the Covered Person until next Benefit Year. In either case: (1) only claims incurred on or after the start of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

If charges incurred by a Covered Person for any dental services are not covered due to the application of any of this Plan's waiting periods pr penalties for Late Entrants, this rollover provision will not apply with respect to the Covered Person until the end of such period.

If such waiting period or Late Entrant penalty ends within the three months prior to the start of this Plan's next Benefit Year, this rollover provision will not apply to the Covered Person until the next Benefit Year. In that case: (1) only claims incurred on or after the start of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

B951.0070

ADULT DENTAL SERVICES

Limitations

Teeth Lost, Extracted or Missing Before a Covered Person Becomes Covered By This Plan: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth or extracted after he or she became covered by this Plan.

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.

- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment, unless the benefit provision provides specific benefits for Orthodontic Treatment.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
- Tooth transplant.
- Evaluations and consultations for non-covered services, or detailed and extensive oral evaluations.
- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence if a dental implant.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

B951.0074

LIST OF ADULT COVERED DENTAL SERVICES

The services covered by this Plan are named in this list. In order to be covered, the service must be furnished by, or under the direct supervision of a Dentist. And it must be usual and necessary treatment for a dental condition.

Group I Services

(Diagnostic & Preventive)

Prophylaxis and Fluorides

Prophylaxis (Adult prophylaxis covered age 12 and older): Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to Covered Persons under age 19 and to one treatment in any six consecutive month period.

Office Visits, Evaluations and Examination

Comprehensive oral evaluation - limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation - problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

Space Maintainers

Space Maintainers: Limited to Covered Persons under age 16 and limited to initial Appliance Only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral.
- Fixed - bilateral.
- Removable - unilateral.

- Removable - bilateral.

Recementation of space maintainer.

Removal of fixed space maintainer is considered once per quadrant or Arch (as applicable) per lifetime.

Fixed and Removable Appliances

Fixed and removable appliances to inhibit thumbsucking: Limited to Covered Persons under age 14 and limited to initial Appliance only. Allowance includes all adjustments in the first six months after insertions.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images - single images.

Dental Sealants

Dental Sealants or Preventive Resin Restoration, permanent molar teeth only: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth of Covered persons under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

B951.0075

Group II Services

(Basic)

Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months have passed since the previous restoration was placed if the Covered Person is or older

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 24 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

B951.0076

Group III Services

(Major)

Group III Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations.

Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch.

B951.0077

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

B951.0078

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

- Root canal treatment. Root canal retreatment - limited to once per tooth, per lifetime.
- Treatment of root canal obstruction, no surgical access.
- Incomplete endodontic therapy, inoperable or fractured tooth.
- Internal root repair of perforation defects.
- Apexification: Limited to a maximum of three visits.
- Apicoectomy: Limited to once per root, per lifetime.
- Root amputation: Limited to once per root, per lifetime.
- Retrograde filling: Limited to once per root, per lifetime.
- Hemisection, including any root removal: Once per tooth.

Periodontal Services

Periodontal maintenance: Limited to total of one periodontal maintenance or prophylaxis in any six month period. Allowance includes periodontal charting, scaling and polishing. Also, see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

Periodontal Services: Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once in any 36 consecutive month period. Considered only when no diagnostic preventive, periodontal maintenance procedure, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

Periodontal Surgery Related

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period afer covered scaling and root planning or osseous surgery.

Occlusal guards: Covered only when done within a six month period after osseous surgery and limited to one per lifetime.

B951.0079

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan** .

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Biopsy and examination of tooth related oral tissue.

Brush biopsy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of tooth related tumors, cysts and neoplasms.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Sailoithotomy.

Sialodochoplasty.

Closure of salivary fistula. Excision of salivary gland.

Maxillary sinusotomy for removal of tooth fragment or foreign body.

Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under Other Surgical Procedures.

B951.0080

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

The provisions listed here apply to Covered persons under the age of 19 and the List of Covered Pediatric Dental Services explained below.

Limitations

Teeth Lost, Extracted or Missing Before a Covered Person Becomes Covered By This Plan: A Covered Person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this Plan. We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth or extracted after he or she became covered by this Plan.

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 60 months old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.

- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

B951.0081

LIST OF COVERED PEDIATRIC DENTAL SERVICES

The list below provides the Pediatric Dental services required by your State. If a Covered Person under the age of 19 is eligible to receive more than one dental benefit for the same service under dental coverage provided by Us, claim payments will be calculated for each benefit and the greater of the two benefits will be paid.

Group I Services

(Diagnostic & Preventive)

Prophylaxis and Fluorides

Prophylaxis: Limited to a total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group II Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, and only when the additional prophylaxis is recommended by the Dentist and is a result of a medical condition as verified in writing by the Covered Person's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application: Limited to Covered Persons under age 19 and to two treatments in any twelve consecutive month period.

Office Visits, Evaluations and Examination

Comprehensive oral evaluation - limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation - problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment limited to a total of one in any six consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

Space Maintainers

Space Maintainers: Limited to initial Appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral.
- Fixed - bilateral.

- Removable - unilateral.
- Removable - bilateral.

Recementation of space maintainer performed more than 12 months after the initial insertion.

Removal of fixed space maintainer is considered once per quadrant or Arch (as applicable) per lifetime.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph: Either but not both of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 6 consecutive month period.

Intraoral periapical or occlusal images- single images.

Dental Sealants

Dental Sealants or Preventive Resin Restoration, permanent molar teeth only: Topical application of sealants is limited to the unrestored, caries free, surfaces of permanent molar teeth. Limited to one treatment, per tooth, in any 36 consecutive month period.

B951.0082

Group II Services

(Basic)

Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if at least 12 months have passed since the previous restoration was placed.

Amalgam restorations: Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 60 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth: Covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment, limited to one consultation for each Covered Dental Specialty in any 12 consecutive month period. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic casts when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

B951.0083

Group III Services

(Major)

Group III Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations.

Single Crowns:

- Resin with metal.
- Porcelain.
- Porcelain with metal.
- Full cast metal (other than stainless steel).
- Titanium.
- 3/4 cast metal crowns.
- 3/4 porcelain crowns.

Inlays.

Onlays, including inlay.

Labial veneers.

Posts and buildups: Only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth.
- Prefabricated post and core in addition to a unit of crown or bridge, per tooth.
- Crown or core buildup, including pins.

Implant supported prosthetics: Allowance includes the treatment plan and local anesthetic, when done in connection with a covered surgical placement of an implant on the same tooth.

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.
- Implant supported retainer for fixed partial denture.
- Implant/abutment supported removable denture for completely edentulous arch.
- Implant/abutment supported removable denture for partially edentulous arch.
- Implant/abutment supported fixed denture for completely edentulous arch.
- Implant/abutment supported fixed denture for partially edentulous arch.
- Dental implant supported connecting bar.
- Prefabricated abutment.
- Custom abutment.

Implant services: Allowance includes the treatment plan, local anesthetic and post-surgical care. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered under this Plan. Also, see the Special Limitations section and Exclusions.

- Surgical placement of implant body, endosteal implant.
- Surgical placement, eposteal implant.
- Surgical placement transosteal implant.

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site: Limited to once per tooth, per lifetime.
- Radiographs/surgical implant index: Limited to once per arch in any 24 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal.

B951.0084

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Special Limitations section and Exclusions.

Fixed bridges: Each abutment and each pontic makes up a unit in a bridge.

Bridge abutments:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal.
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent Appliance.

Complete or immediate dentures, upper or lower.

Partial dentures: Allowance includes base, clasps, rests and teeth.

- Upper, resin base, including any conventional clasps, rests and teeth.
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Lower, resin base, including any conventional clasps, rests and teeth.
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth.
- Interim partial denture (stayplate), upper or lower, covered on Anterior Teeth only.
- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

Crown and bridge repairs: Allowance based on the extent and nature of damage and the type of material involved.

Recementation: Limited to recementations performed more than 12 months after the initial insertion.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

Denture repairs: Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal.
- Denture repairs, acrylic.
- Denture repair, no teeth damaged.
- Denture repair, replace one or more broken teeth.
- Replacing one or more broken teeth, no other damage.

Denture rebase, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six months are considered to be part of the denture placement when the adjustment is done by the Dentist who furnished the denture. Limited to adjustments that are done more than six consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under Other Surgical Procedures.

Detailed and extensive oral evaluations - problem focused, by report

B951.0085

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping: Limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

- Pulp capping, direct.
- Pulp capping, indirect: Includes sedative filling.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

- Root canal treatment, Root canal retreatment: Limited to once per tooth, per lifetime.
- Treatment of root canal obstruction, no surgical access.
- Incomplete endodontic therapy, inoperable or fractured tooth.
- Internal root repair of perforation defects.
- Apexification: Limited to a maximum of three visits.
- Apicoectomy: Limited to once per root, per lifetime.
- Root amputation: Limited to once per root, per lifetime.
- Retrograde filling: Limited to once per root, per lifetime.
- Hemisection, including any root removal: Once per tooth.

Periodontal Services

Periodontal maintenance: Limited to a total of four periodontal maintenance or prophylaxis in any twelve month period. Allowance includes periodontal charting, scaling and polishing. Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

Periodontal Services: Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Scaling and root planing, per quadrant: Limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement: Limited to once per lifetime.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved. Considered when performed to retain teeth.

The treatment listed below is limited to a total of one of following, once per tooth in any 12 consecutive month period.

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

The treatment listed below is limited to a total of one of the following, once per quadrant, in any 36 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant.
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant.
- Gingival flap procedure, including scaling and root planing, per quadrant.
- Distal or proximal wedge procedure, not in conjunction with osseous surgery.
- Surgical revision procedure, per tooth.

The treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

The treatment listed below is limited to a total of one of the following, once per area or tooth, per lifetime, when the tooth is present.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

Periodontal Surgery Related

Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

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Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

- Uncomplicated extraction, one or more teeth.
- Root removal, non-surgical extraction of exposed roots.

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan** .

Surgical removal of erupted teeth, involving tissue flap and bone removal.

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. **Services listed in this category and related services may be covered by Your Employer's medical plan.**

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Vestibuloplasty.

Tooth reimplantation.

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Group IV Services

(Orthodontics)

Orthodontic Services

Prior authorization is required for Orthodontic Services. Orthodontic Services are covered when needed to due to severe, dysfunctional, handicapping malocclusion.

- Orthodontic records includes exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, interceptive Orthodontic Treatment, or comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits. Minor treatment to control harmful habits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

Treatment Plan

A treatment plan should always be sent to us before Orthodontic Treatment starts.

How We Pay Benefits for Orthodontic Services

Using the Covered Person's original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this Plan.

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The negotiated discounted fees for orthodontics performed by a Preferred Provider include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fix and removable appliances and related visits; and (c) limited, interceptive and comprehensive orthodontic treatment, with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for Orthodontic Treatment which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a Preferred Provider does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in Orthodontic Treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; and (e) orthodontic treatment started before the member was eligible for orthodontic benefits under this Plan. Whether or not a charge is based on a discounted fee, it will be counted toward a Covered Person’s orthodontic lifetime payment limited under this Plan.

B951.0088

CONTINUATION RIGHTS

Coordination Between Continuation Sections

A Covered Person may be eligible to continue his or her group dental coverage under more than one Continuation Rights section at the same time. If he or she chooses to continue his or her group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

A Covered Person continuing coverage under more than one continuation section: (1) will not be entitled to duplicate benefits; and (2) will not be subject to the premium requirements of more than one section at the same time.

Uniformed Services Continuation Rights

If You enter or return from military service, You may be able to continue coverage under this Plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If Your group dental coverage under this Plan would otherwise end because You enter into active military service, You may elect to continue such coverage for yourself and Your eligible dependents in accordance with the provisions of USERRA.

Group dental coverage may be continued while You are in the military for up to 24 months starting on the date of absence from work. Continued coverage will end if You fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact Your Employee for details about this continuation provision, including required premium payments.

COBRA Continuation Rights Employee and Dependent

Important Notice: The Federal Continuation Rights section may not apply to Your Employer's plan. You must contact Your Employer's to find out if Your Employer's is subject to the Federal continuation rights requirement. If Your Employer's is subject to that requirement, the Federal Continuation Rights section applies to You. State of Rhode Island COBRA rules (RIGL 27-19.1-1) apply in all instances of Employee and Dependent COBRA Continuation Rights in the State of Rhode Island.

Qualified Continuee: Under this section, the term "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group dental coverage as: (1) an active Employee or Qualified Retiree; (2) the spouse of an active Employee Qualified Retiree; or (3) the dependent child of an active Employee Qualified Retiree. A child born to, or adopted by, an active Employee Qualified Retiree during a continuation provided by this section is also a qualified continuee. Any other person who would otherwise become eligible for group dental coverage during a continuation provided by this section is not a qualified continuee.

If an Employee's Group Dental Coverage Ends: If Your group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, You may elect to continue such coverage for up to 18 months, if You were not terminated due to gross misconduct.

The continuation: (1) may cover You or any other qualified continuee; and (2) is subject to When Continuation Ends.

Extra Continuation for Disabled Qualified Continuees: If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give Your Employer written proof of Social Security's determination of his or her disability as described in The Qualified Continuee's Responsibilities. If, during the extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify Your Employer within 30 days of such determination and continuation will end, as explained in When Continuation Ends.

This extra 11 month continuation is subject to When Continuation Ends.

An additional 50% of the total premium charge also may be required from the qualified continuee and all qualified continuees who are members of the disabled qualified continuee's family by Your Employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

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Special Continuance for Retired Employees and Their Dependents: If Your group dental coverage would otherwise end due to a bankruptcy proceeding under Title 11 of the United States Code involving the Employer, You may elect to continue such benefits, provided that: (1) You are or become a retired Employee on or before the date group dental coverage would otherwise end; and (2) You and Your dependents were covered for group dental coverage under this Plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for Your lifetime. After Your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for You and Your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If You die before the bankruptcy proceeding under Title 11 of the United States Code, Your surviving spouse and dependent children may elect to continue group dental coverage on their own behalf, provided they were covered on the day before such proceeding. The continuation can last for Your surviving spouse's lifetime.

This special continuance starts on the later of (1) the date of the proceeding under Title 11; or (2) the day after the date group dental coverage would otherwise have ended. It ends as described in When Continuation Ends, except that a person's entitlement to Medicare will not end such continuance.

If You Die While Covered: If You die while covered, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

If Your Marriage Ends: If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

If a Dependent Child Loses Eligibility: If a dependent child's group dental coverage would otherwise end due to his or her loss of dependent eligibility as defined in this Plan, other than Your coverage ending, he or she may elect to continue such coverage. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to When Continuation Ends.

Concurrent Continuations: If a dependent elects to continue his or her group dental coverage due to Your termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period he or she becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule: If You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after Your later termination of employment or reduction of work hours, will be the longer of: (1) 18 months (29 months if there is a disability extension) from Your termination of employment or reduction of work hours; or (2) 36 months from the date of Your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this section must notify Your Employer, in writing, of: (1) Your legal divorce or separation from Your spouse; (2) the loss of dependent eligibility, as defined in this Plan, of a covered dependent child; (3) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (4) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (5) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to Your Employer by a qualified continuee within 60 days of the latest of: (1) the date on which an event that would qualify a person for continuation under this section occurs; (2) the date on which the qualified continuee loses(or would lose) coverage under this Plan as a result of the event; or (3) the date the qualified continuee is informed of the responsibility to provide notice to Your Employer and this Plan's procedures for providing such notice.

Notice of a disability determination must be given to Your Employer by a qualified continuee within 60 days of the latest of: (1) the date of the Social Security Administration determination; (2) the date of the event that would qualify a person for continuation; (3) the date the qualified continuee loses or would lose coverage; or (4) the date the qualified continuee is informed of the responsibility to provide notice to Your Employer and this Plan's procedures for providing such notice. But, such notice must be given before the end of the first 18 months of continuation coverage.

Your Employer's Responsibilities: A qualified continuee must be notified, in writing, of: (1) his or her right to continue this Plan's group dental coverage; (2) the premium he or she must pay to continue such coverage; and (3) the times and manner in which such payments must be made.

Your Employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (1) Your death; or (2) termination of employment (other than for gross misconduct) or reduction in hours of employment; or (3) Medicare entitlement; or (4) if You are a retired Employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to Your Employer. Upon receipt of notice of a qualifying event from Your Employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this Plan's group dental coverage no later than 14 days after receipt of notice.

If Your Employer is also the plan administrator, in the case of a qualifying event for which the Employer must give notice to the plan administrator, Your Employer must provide notice to a qualified continuee of the right to continue this Plan's group dental coverage within 44 days of the qualifying event.

If Your Employer determines that a person is not eligible for continued group dental coverage under this Plan, Your Employer must notify him or her with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group dental coverage under this Plan is cancelled prior to the maximum continuation period, Your Employer must notify the qualified continuee as soon as practical following determination that the continued group dental coverage shall terminate.

Your Employer's Liability: Your Employer will be liable for the qualified continuee's continued group dental coverage to the same extent as, and in place of, Us, if Your Employer fails: (1) to remit a qualified continuee's premium payment to Us on time, causing the qualified continuee's continued group dental coverage to end; or (2) to notify the qualified continuee of his or her continuation rights as described above.

Election of Continuation: To continue his or her group dental coverage, the qualified continuee must give Your Employer written notice that he or she elects to continue. This must be done by the later of: (1) 60 days from the date a qualified continuee receives notice of his or her continuation rights from Your Employ as described above; or (2) the date group dental coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to Your Employer, by the qualified continuee, in advance, at the times and in the manner specified by Your Employer. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group dental coverage had the qualified continuee stayed covered under the group Plan on a regular basis. It includes any amount that would have been paid by Your Employer. Except as explained in Extra Continuation For Disabled Qualified Continuees, an additional charge of two percent of the total premium charge may also be required by Your Employer.

If the qualified continuee fails to give Your Employer notice of his or her intent to continue, or fails to pay any required premium in a timely manner, he or she waives his or her continuation rights.

Grace In Payment of Premium: A qualified continuee's premium payment is timely if, with respect to the first payment after he or she elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made in an amount that is not significantly less than the amount the Plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid, unless Your Employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to Your Employer.

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When Continuation Ends: A qualified continuee's continued group dental coverage ends on the first of the following:

- With respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental coverage would otherwise end;
- With respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (1) the end of the 29 month period which starts on the date the group dental coverage would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- The date Your Employer ceases to provide any group dental coverage to any Employee;
- The end of the period for which the last premium payment is made;
- The date, after the date of election, a qualified continuee becomes covered under any other group dental coverage which does not contain any pre-existing condition exclusion or limitation affecting him or her;
- The date, after the date of election, the qualified continuee becomes entitled to Medicare; or
- With respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group dental coverage would otherwise end.

Your Right to Continue Dental Expense Coverage During a Family Leave of Absence

Important Notice: This section may not apply to Your Employer's plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

If Your Coverage Would End: Your dental expense coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious injury or illness arising out of the fact that Your spouse, child, parent or next of kin who is a covered servicemember is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date You return to Active Work.
- The end of a total leave period of 26 weeks in one 12 month period, if You care for a covered servicemember. This 26 week total leave period applies to all leaves granted to You under this section for all reasons.
- The end of a total leave period of 12 weeks in: (1) any later 12 month period, if You care for a covered servicemember; or (2) any 12 month period in any other case.
- The date on which Your coverage would have ended had You not been on leave.
- The end of the period for which premium has been paid.

Definitions: As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered servicemember, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

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COORDINATION OF BENEFITS

Purpose: When a Covered Person has coverage for dental expenses under more than one plan, this section allows this Plan to coordinate what it pays with what other plans pay. This is done so that the Covered Person does not collect more in benefits than he or she incurs in charges.

Definitions

For the purposes of this section, the following terms are defined as:

Allowable Expense: This term means any necessary, reasonable, and customary item of dental expense that is covered, at least in part, by any of the plans which cover the person. This includes: (1) deductibles; (2) coinsurance; and (3) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (1) second surgical opinions; (2) precertification of admissions; and (3) preferred provider arrangements.
- If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim: This term means a request that benefits of a plan be provided or paid.

Claim Determination Period: This term means a calendar year. It does not include any part of a year during which a person has no coverage under this Plan, or before the date this section takes effect.

Closed Panel Plan: This term means a health maintenance Organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides dental benefits to Covered Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Coordination of Benefits: This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent: This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contracts: This term means contracts: (1) which are not available to the general public; and (2) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.

Plan: This term means any of the following that provides benefits or services for dental care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) medical benefits under group or individual automobile contracts; and (5) governmental benefits, except Medicare, as permitted by law.

This term does not include: (1) individual or family insurance; (2) closed panel or other individual coverage, except for group-type coverage; (3) school accident type coverage; or (4) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

Primary Plan: This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan: This term means a plan that is not a primary plan.

This Plan: This term means the group dental benefits provided under this group Plan.

Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that apply is the rule to use.

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Non-Dependent or Dependent: The plan that covers the person other than as a dependent (for example, as an Employee, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an Employee, subscriber, or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan: The order of benefit determination when a child is covered by more than one plan is:

- If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
- If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (1) the plan of the custodial parent; (2) the plan of the spouse of the custodial parent; (3) the plan of the noncustodial parent; and (4) the plan of the spouse of the noncustodial parent.

Active or Inactive Employee: The plan that covers a person as an active Employee, or as that person's dependent, is primary. An active Employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired Employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Continuation Coverage: The plan that covers a person as an active Employee, member, subscriber, or retired Employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length of Coverage: The plan that covered the person longer is primary.

Other: If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this Plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan Is Primary: When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

When This Plan Is Secondary: When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

Closed Panel Plans: If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a Covered Person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

Certain facts about dental coverage and services are needed to apply these rules and to determine benefits payable under this Plan and other plans. This Plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this Plan and other plans which cover the person claiming benefits. This Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this Plan. If it does, this Plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this Plan. This Plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by this Plan is more than it should have paid under this section, it may recover the excess: (1) from one or more of the persons it has paid or for whom it has paid; or (2) from any other person or organization that may be responsible for benefits or services provided for the Covered Person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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SCHEDULE OF BENEFITS

The Guardian Life Insurance Company of America
A Mutual Company - Incorporated 1860
by the State of New York
7 Hanover Square, New York, New York 10004

This plan includes pediatric dental services as required under the federal Patient Protection and Affordable Care Act.

The Plan refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect.

Please read the entire Certificate of Coverage to fully understand all terms, conditions, limitations and exclusions that apply.

Policy Number:
Employee Name:
Employee Address:
Dependent(s):

Date these benefits take effect: These benefits begin on the effective date of the Policy which provides Group Pediatric Dental Expense Coverage for Covered Person(s) under the age of 19, or the effective date of any amendment which adds such Policy.

NON-PEDIATRIC SCHEDULE

CASH DEDUCTIBLE INFORMATION

Deductible per Insured per Benefit Year

Preferred Provider Benefit Year Cash Deductible:

Group I Services . . . . . None

Group II and Group III Services $50.00

Non-Preferred Provider Benefit Year Cash Deductible:

Group I Services . . . . . None

Group II and Group III Services $50.00

PAYMENT RATES

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider. This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by any medical plan.

Preferred Provider Payment Rates:

Group I Services 100%

Group II Services 80%

Group III Services 50%

Group IV (Orthodontic) Services 0%

Non-Preferred Provider Payment Rates:

Group I Services 100%

Group II Services 60%

Group III Services 40%

Group IV (Orthodontic) Services 0%

MAXIMUMS AND WAITING PERIODS

Preferred Provider and Non-Preferred Provider

Annual Maximum per Covered Person $1,500.00

Preferred Provider and Non-Preferred Provider Waiting Periods

Group I and Group II Services . . . . . None

Group III Services (Orthodontics) . . . . . 12 Months

PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons under the age of 19 who are eligible for the Pediatric Dental Services explained in the attached Dental Certificate of Coverage.

IN THE EVENT THE COVERED PERSON IS ELIGIBLE FOR MORE THAN ONE DENTAL BENEFIT THROUGH COVERAGE PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA, FOR THE SAME SERVICE, THE GREATER OF THE TWO BENEFITS WILL BE PAID.

PEDIATRIC DENTAL SERVICES CASH DEDUCTIBLE INFORMATION

Deductible per Insured Child per Benefit Year

Preferred Provider Benefit Year Cash Deductible:

Group I Services . . . . . None

Group II and Group III Services $50.00

Group IV (Orthodontic) Services . . . . . None

Non-Preferred Provider Benefit Year Cash Deductible:

Group I Services . . . . . None

Group II and Group III Services $50.00

Group IV (Orthodontic) Services . . . . . None

PEDIATRIC DENTAL SERVICES PAYMENT RATES

Preferred Provider Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

Preferred Provider Payment Rates:

Group I Services 100%

Group II Services 80%

Group III Services 50%

Group IV (Orthodontic) Services 50%

Non-Preferred Provider Payment Rates:

Group I Services 100%

Group II Services 60%

Group III Services 40%

Group IV (Orthodontic) Services 30%

PEDIATRIC DENTAL SERVICES MAXIMUMS AND WAITING PERIODS

Preferred Provider & Non-Preferred Provider Annual Maximums:

Group I, Group II, Group III and Group IV (Orthodontics) Services . . . . None

Preferred Provider and Non-Preferred Provider Orthodontic Lifetime Maximum . . . . . None

Preferred Provider Out of Pocket Annual Maximum Per Covered Child $350.00

Preferred Provider Out of Pocket Annual Maximum for Two or More Covered Children $700.00

(The **Preferred Provider Out of Pocket Annual Maximum** will apply each year. Any amount paid for covered pediatric dental services by a Covered Person applies toward satisfaction of the out of pocket maximum. Once the annual out of pocket maximum is reached, Covered Charges for services performed by a Preferred Provider will be reimbursed at 100%.)

Non-Preferred Provider Out of Pocket Annual Maximum . . . . . None

Preferred Provider and Non-Preferred Provider Waiting Periods:

Group I, Group II, Group III and Group IV (Orthodontics) Services . . . . None

In an emergency, if a participating provider is not available within twenty-four (24) hours of an enrollee s request or on the same day, if medically indicated, and the enrollee has no option but to receive covered emergency treatment from a non-participating provider, upon written notification to, and verification of the circumstances by, Guardian, the claim for such covered emergency treatment will be reimbursed at the in-network rate. Reimbursement at the in-network rate for such covered emergency treatment by a non-participating provider will be limited to only those covered dental procedures that are needed for the relief of acute pain, acute swelling, or treatment of trauma.