THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
7 Hanover Square
New York, New York 10004

INDIVIDUAL DENTAL BENEFITS PLAN

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

THE INSURANCE EVIDENCED BY THIS PLAN PROVIDES DENTAL INSURANCE ONLY.

Planowner: Refer to Your ID Card
Plan Number: Refer to Your ID Card
Plan Effective Date: The Effective Date Approved by Us
Plan Anniversary: The Anniversary Date of the Effective Date, Each Year.

The Guardian (referred to in this Plan as "THE GUARDIAN," "us," "we," or "our"), in consideration of the application for this Plan and of the payment of premiums as stated herein, agrees to provide benefits in accordance with and subject to the terms of this Plan.

THE GUARDIAN AGREES to provide benefits in accordance with, and subject to, the terms of this Plan. This promise is based on the statements and agreements in the Application and payment of the required premiums. Please check the application form for errors. An incorrect or incomplete application may cause the Plan to be voided and claims to be reduced or denied.

THIS IS A PREPAID LIMITED HEALTH SERVICE PLAN IS PROVIDED BY THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA LICENSED UNDER FLORIDA LAW.

NOTICE TO BUYER: THIS IS A LIMITED BENEFIT DENTAL PLAN. THIS PLAN PROVIDES DENTAL BENEFITS ONLY. PLEASE READ THIS PLAN CAREFULLY.

TERM OF PLAN
This Plan is issued for a term of one year from the Plan Effective Date. All Plan years and Plan months will be calculated from the Plan Effective Date. All periods of coverage will begin and end at 12:01 AM Standard Time at the Planowner's place of residence, subject to the Grace In Payment Of Premiums. This Plan may then be renewed subject to the Renewal At The Option Of The Company provision.

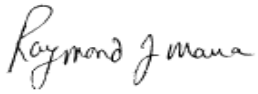
RENEWAL AT THE OPTION OF THE COMPANY
This Plan is conditionally renewable and will continue in effect as long as the premiums are paid when they are due or within the grace period in accordance with the terms and conditions of this Plan.

This Plan may be renewed for a further term by timely payment of renewal, unless We send prior notice of Our intention not to renew. If We do refuse to renew We must do so on all Policies of this form issued under the same class in the state. At least 60 days prior to the premium due date, We will send written notice of non-renewal to the last known address shown on record. Non-renewal will not affect any otherwise valid claim that starts while this Plan is in force.

If We raise the premium due to a change in rates, then at least 30 days advance written notice will be given prior to any change in rates, and will be sent to the last known address shown on record.

TEN-DAY RIGHT TO EXAMINE PLAN
There is a 10 day right to examine this Plan. If not satisfied for any reason this Plan may be returned to THE GUARDIAN within 10 days of receipt to have the premium refunded.

In Witness Whereof, THE GUARDIAN has caused this Plan to be executed as of the Effective Date Approved by Us, which is its date of issue.



Raymond Marra

Senior Vice President, Group Products and Marketing

Premium Rates

The monthly premium rates, in U.S. dollars, for the coverage provided under this Plan are as follows:

Your monthly premium rates appear on Your Payment Notice.

We have the right to change any premium rate(s) set forth at the times and in the manner established by the provisions contained in this Plan entitled "Premiums."

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GENERAL PROVISIONS

Effective Date

This Plan will: (a) be effective on the Plan effective date shown on the face page of this Plan; and (b) continue until the last day of the month in which the termination of this Plan occurs. All coverage under the Plan shall begin and end at 12:01 A.M., Standard Time at the Planowner's place or residence.

Premium Payments

The first premium payment for this Plan is due on the Plan effective date. Further payments shall be made on the first day of each month for each month this Plan is in effect. The Guardian may change such rates on the first day of any month. The Guardian must give You 30 days written notice of the rate change. Such change will apply to any premium due on or after the effective date of the change stated in such notice.

Limitation Of Authority

No agent is authorized: (a) to alter this Plan; (b) to waive any conditions or restrictions contained in this Plan; (c) to extend the time for paying a premium; or (d) to bind The Guardian by making any promise or representation, or by giving or receiving any information.

No change in this Plan will be valid unless evidenced by an endorsement or rider to this Plan signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of The Guardian. The Guardian must give You 30 written notice of a change.

Entire Contract

This Plan, and application, constitutes the entire agreement of the parties. This Plan may only be modified by a writing executed by the parties.

Disputes Between Parties

Any dispute, grievance, or controversy arising between Planowner and The Guardian or between a Member and The Guardian involving this Plan, any of its terms or conditions, its breach or non-performance may be settled, if both parties agree, by arbitration pursuant to the rules and regulations then in force and effect of the Florida Arbitration Act, Chapter 682 of the Florida statutes. The arbitration will take place in Florida and judgment on any award rendered by the arbitrator may be duly entered in any court in the State of Florida having jurisdiction thereof. The prevailing party shall be entitled to court costs and reasonable attorney's fees.

Notice

Whenever it shall become necessary for either party to serve notice on the other with respect to this Plan, such notice shall be in writing and shall be served by certified mail, return receipt requested, addressed as follows:

If to a Planowner: At the Planowner's most current address on file with The Guardian (It is the Planowner's responsibility to timely notify The Guardian of address changes.)

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

Conformity With Statutes

This Plan shall be governed by the laws of the State of Florida.

Unenforceability, Invalidity Or Waiver Or Any Violation

Of Any Provision Of The Plan

If any provision of this Plan is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Plan and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Plan.

Non-Assignability

This Plan is non-assignable by either party without consent of the other party. The Guardian may, in its sole discretion, delegate administration functions to other entities. Any attempt to make such an assignment shall be void and may result, at The Guardian's option, in the termination of a Member's coverage.

Incontestability

This Plan shall be incontestable after two years from its Effective Date, except for non-payment of Premiums. No statement in any application, except a fraudulent statement, made by a Member may be used in contesting the validity of his or her coverage or denying a claim for a loss incurred, after such insurance has been in force for two years during his or her lifetime.

Clerical Error – Misstatements

Neither clerical error by You or The Guardian in keeping any records pertaining to coverage under this Plan, nor delays in making entries thereon, will: (a) invalidate coverage otherwise in force; or (b) continue coverage otherwise validly terminated. Upon discovery of such error or delay, an equitable adjustment of premiums will be made.

If the age of a Member, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of fees will be made. If such misstatement involves whether or not a risk would have been accepted by Us, or the amount of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amount.

Statements

Termination at such time other than the renewal period mey be for fraud or material misrepresentation in applying for or presenting any claim for benefits under the Plan .

All statements will be deemed representations and not warranties.

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Plan was issued, the coverage under this Plan will be exempt from execution, garnishment, attachment or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Examinations

We have a right to have a doctor or Dentist of our choice examine a person for whom a claim is being made under this Plan as often as may be reasonably necessary while a claim is pending. We'll pay for all such examinations.

Premiums

You must pay The Guardian the total sum indicated in the "Premium Rates" section of this Plan, per Member per month, commencing on the Plan effective date shown on the face page of this Plan. Payment will be made on the first day of the month for each month this Plan is in effect. You must pay premiums due under this Plan at an office of The Guardian or to a representative that We have authorized.

Adjustment Of Premiums

The premiums due under this Plan on each due date will be the sum of each premium per Member covered by this Plan.

We may change such premiums: (a) on the first day of each Plan month; or (b) on any date Our obligation under this Plan with respect to You is changed because of statutory or other regulatory requirements; (d) if this Plan supplements or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan or health or dental maintenance organization, on any date our obligation under this Plan is changed because of a change in such other benefits. We will provide You with 60 days advance written notice of any premium changes.

Grace Period – Termination Of Plan

A grace period of 31 days, or a period of 3-months for individuals receiving advance payments of the premium tax credit, without interest charge, will be granted to You for each premium except the first. The Plan will remain in force during the grace period. If any premium is not paid before the end of the grace period, this Plan automatically terminates on the last day of the month to which the grace period applies. You will still owe Us premiums for the month this Plan was in effect during the grace period.

Renewal Of Plan

You or The Guardian may renew this Plan at the end of the term thereof, and by mutual consent modify, or alter this Plan at renewal provided that said modifications, alterations or renewals shall be in writing, duly executed by both parties hereto and attached to this Plan.

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures: You may enroll Yourself and Your Dependents for dental coverage by: filling out and signing The Guardian's enrollment form and any additional material required by The Guardian.

The Guardian will issue You and Your Dependents a Guardian MDG ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

When Coverage Starts: Your Coverage starts on the date shown on the face page of this Plan.

As the Planowner, You may enroll Yourself alone, or together with Your spouse and/or eligible dependent children (subject to age limits in the Plan). If You do not enroll Your Dependent(s) on the date You enroll, You must wait to add them until the next open enrollment period.

Dependents may be added, deleted, or you may change your coverage status on the date of the qualifying event, provided that We are notified in writing at least 31 days after the date of the qualifying event.

Newborn children may be enrolled on the date of the birth, if We are given written notice within 60 days of the date of birth. Children that are newly acquired Dependents through adoption or children placed for adoption may be enrolled on the date of adoption or placement for adoption, if We are given written notice within 60 days of the qualifying event.

Qualifying Events

1. Marriage
2. Birth
3. Adoption
4. Children Placed for Adoption
5. Becoming a legal guardian of a child
6. Divorce
7. Death

When Coverage Ends: A Member's coverage under this Plan ends on the first to occur:

1. The end of the Plan term or at the end of the grace period if premiums are not paid.;
2. A member fails to pay required premium and the 3-month grace period required for members receiving advance payments of the premium tax credit has been exhausted;
3. The end of the month in which the Member is no longer eligible for coverage under this Plan;
4. The date on which no Member resides or works in the Service Area;
5. The end of the month during which You receive written notice from the Member requesting termination of coverage, or on such later date as requested by the notice;
6. 45 days after Guardian sends written notice to a Member advising that his or her coverage will end because the Member has: (a) knowingly given false information in writing on his or her enrollment form; or (b) misused his or her ID card or other documents provided to obtain benefits under this Plan; or (c) otherwise acted in an unlawful or fraudulent manner regarding Plan services and benefits. Prior to termination, We shall make an effort to resolve the problem through the grievance procedure and we shall determine that the Member's behavior is not due to use of the services provided or mental illness..; or
7. The exchange may initiate termination of a Member's coverage in a QHP, and must permit Us to terminate such coverage, in the following circumstances: (i) The Member is no longer eligible for coverage in a QHP through the exchange; (ii) Non-payment of premiums for coverage of the Member, and the 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted; or, (iii) The Member's coverage is rescinded; (iv) The QHP terminates or is decertified; or (v) The Member changes from one QHP to another during an annual open enrollment period or special enrollment period.

Extended Dental Expense Benefits: If a Member's coverage ends, We extend dental expense benefits for him or her under this Plan as explained below.

We extend benefits for covered services only if the procedure(s) are: (a) started before the Member's coverage ends; and (b) has been completed or for 90 days after the date his or her coverage ends. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. Root canal is started when the pulp chamber is opened. Comprehensive orthodontic treatment is started when the teeth are banded.

The extension of benefits ends on the first to occur of: (a) 90 days after the Member's coverage ends; or (b) the date he or she becomes covered under another plan which provides coverage for similar dental procedures. But, if the plan which succeeds this Plan excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the Member's coverage ends.

And what We pay is based on all the terms of this Plan.

Termination of the Plan by Us shall be without prejudice to any continuous loss which commenced while the Plan was in force. Extension of benefits beyond the period the Plan was in force shall be until the specific treatment or procedure undertaken upon any Member has been completed or for 90 days, whichever is the lesser period of time.

Open Enrollment: You can enroll under this Plan during an open enrollment period that runs from November 1 of the prior calendar year through January 31 of the following calendar year. If the exchange receives Your selection on or before December 15 of the prior calendar year, Your coverage will begin on January 1 of the following calendar year, as long as the applicable premium payment is received by then. If the exchange receives Your selection between December 16 of the prior calendar year through January 15 of the following calendar year, Your coverage will begin on February 1, as long as the applicable premium payment is received by then. If the exchange receives Your selection between January 16 through January 31, Your coverage will begin on March 1 as long as the applicable premium payment is received by then.

If You do not enroll during open enrollment, or during a special enrollment period as described below, You must wait until the next annual open enrollment period to enroll.

Special Enrollment Periods: Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days prior to or after the occurrence of one of the following events:

1. You or Your Spouse or Child involuntarily lose minimum essential coverage, including COBRA, including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the premium tax credit because coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child lose eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary or specialty care; or;
4. You, Your Spouse or child move and become eligible for new qualified dental plans.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child's enrollment or non-enrollment in another qualified dental plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the the exchange, or a non-exchange entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the exchange;

2. You, Your Spouse or Child adequately demonstrate to the exchange that another qualified dental plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption, or placement in foster care or through a child support order or other court order, however, foster children and Children for whom You are a legal guardian are not covered under this Plan;
4. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or if You or Your Dependents die;
5. If You are an Indian, as defined in 25 U.S.C. 450b(d), You may enroll in a qualified dental plan or change from one (1) qualified dental plan to another one (1) time per month;
6. You, Your Spouse or Child demonstrate to the exchange that You meet other exceptional circumstances as the exchange may provide;
7. You, Your Spouse or Child were not previously a citizen, national, or lawfully present individual and You gain such status; or
8. You, Your Spouse or Child are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions.

The exchange must receive notice and We must receive any premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, You are determined newly eligible for advance payments of the premium tax credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or you gain access to new qualified health plans because You are moving, and Your selection is made before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and the exchange receives notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which the exchange receives notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth. If You have individual or individual and Spouse coverage You must also notify the exchange of Your desire to switch to parent and child/children or family coverage and pay any additional premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the exchange receives notice, provided that You pay any additional premium when due.

Advance payments of any premium tax credit are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

If You, Your Spouse or Child enroll because You or Your Dependents die, Your coverage will begin on the first day of the month following Your selection.

In all other cases, the effective date of Your coverage will depend on when the exchange receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable premium payment is received by then.

DENTAL BENEFITS PLAN

This Plan will cover many of a Member's dental expenses. MDG decides: (a) the requirements for benefits to be paid; and (b) what benefits are to be paid by this Plan. We also interpret how this Plan is to be administered. What we cover and the terms of coverage are explained below.

Managed DentalGuard – This Plan's Dental Coverage Organization

Managed DentalGuard: This Plan is designed to provide quality dental care while controlling the cost of such care. To do this, this Plan requires Members to seek dental care from Participating Dentists that belong to the Managed DentalGuard network (MDG network). The MDG network is made up of Participating Dentists in the plan's approved Service Area. A "Participating Dentist" is a Dentist that has a participation agreement in force with Us.

When a Member enrolls in this Plan, he or she will get information about current MDG Participating General Dentists. Each Member must be assigned to a Primary Care Dentist (PCD) from this list of Participating General Dentists. This PCD will coordinate all of the Member's dental care covered by this Plan. After enrollment, a Member will receive a Guardian MDG ID card. A Member must present this ID card when he or she goes to his or her PCD.

What we cover is based on all the terms of this Plan. Read this Plan carefully for: specific benefit levels, payment rates, payment limits, conditions, exclusions and limitations and Patient Charges.

Members may call the MDG Member Services Department if they have any questions after reading this Plan.

Choice Of Dentists: A Member may request any available Participating General Dentist as his or her PCD. A request to change a PCD must be made to Guardian. Any such change will be effective the first day of the month following approval; however, Guardian may require up to 30 days to process and approve any such request. All fees and Patient Charges due to the Member's current PCD must be paid in full prior to such a transfer.

Right to Reassign Member: Guardian reserves the right to reassign Members to a different Participating Dentist in the event that either: (a) the Member's Dentist is no longer a Participating Dentist in the MDG network; or (b) MDG takes an administrative action which impacts the Dentist's participation in the network. Guardian will notify the Member of the dentist's network status change in writing as soon as reasonably possible. If this becomes necessary, the Member will have the opportunity to request another Participating Dentist. If a Member has a dental service in progress at the time of the reassignment, Guardian will, in its discretion and subject to applicable law, either: (a) arrange for completion of the service by the original dentist; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service.

Refusal of Recommended Treatment: A Member may decide to refuse a course of treatment recommended by his or her PCD or specialty care dentist. The Member can request and receive a second opinion by contacting Member Services. If the Member still refuses the recommended course of treatment, the PCD or specialty care dentist may have no further responsibility to provide services for the condition involved and the Member may be required to select another PCD or specialty care dentist.

If Guardian Fails To Pay Participating Dentist: In the event Guardian fails to pay a Participating Dentist, the Member shall not be liable to the Participating Dentist for any sums owed by Guardian.

Relationship Between You And Participating Dentists And Institutions: You understand that: (a) the operation and maintenance of the participating dental offices, facilities and equipment; and (b) the rendition of all dental services are under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) the supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment.

Guardian will undertake to see that the services provided to Members by Participating Dentists will be performed in accordance with professional standards prevailing in the county in which each Participating Dentist practices.

Guardian compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount each month. The amount a Participating General Dentist is paid is based upon the number of Members who have the Dentist assigned as their PCD. MDG may also make minimum monthly payments, supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation a Participating General Dentist receives from Guardian. The Dentist

also receives compensation from Members who may pay an office visit charge for each office visit and a Patient Charge for specific dental services. The schedule of Patient Charges is shown in the Covered Dental Services and Patient Charge section of this Plan.

Specialty Care Referrals: A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Participating Specialty Care Dentist. Guardian will pay for covered services for specialty care, less any applicable Patient Charges, when such covered services are provided in accordance with the specialty referral process described below.

Guardian compensates its Participating Specialty Care Dentists the difference between their contracted fee and the Patient Charge shown in the Covered Dental Services And Patient Charges section. This is the only form of compensation that Participating Specialty Care Dentists receive from Guardian.

ALL SPECIALTY CARE REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY GUARDIAN; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALTY CARE SERVICES WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty care services to be covered by this Plan, the specialty referral process stated below must be followed:

(1) A Member's PCD must coordinate all dental care.

(2) When the care of a Participating Specialty Care Dentist is required, the Member's PCD must contact Guardian and request authorization.

(3) If the PCD's request for specialty care referral is approved, the Member will be notified by Guardian and instructed to contact the Participating Specialty Care Dentist to schedule an appointment.

(4) If the PCD's request for specialty referral is denied as not medically necessary (an adverse determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. (See Appeal of Adverse Determination, below, under Complaint and Appeal Procedures.)

(5) If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide more information.

(6) A specialty referral is not a guarantee of covered services. The Plan's benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a covered service in the Plan, the Member will be responsible for the entire amount of the Specialist's charge for that service.

(7) A Member who receives authorized specialty services is responsible for all applicable Patient Charges for the services provided.

When specialty dental care is authorized by Guardian, a Member will be referred to a Participating Specialty Care Dentist for treatment. The MDG network includes Participating Specialty Care Dentists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Plan's approved Service Area. If there is no Participating Specialty Care Dentist in the Plan's approved Service Area, Guardian will refer the Member to a Non-Participating Specialty Care Dentist of Guardian's choice. In no event will Guardian pay for dental care provided to a Member by a Specialty Care Dentist not pre-authorized by Guardian to provide such services.

Emergency Dental Services: We provide for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. A Member should contact his or her selected and assigned PCD, who will make arrangements for such care. If the Member is unable to reach his or her PCD in an emergency during normal business hours, he or she must contact Our Member Services Department for instructions. If the Member is not able to reach his or her PCD in an emergency after normal business hours, the Member may seek Emergency Dental Services from any Dentist. Then, within 2 business day, he or she should call Guardian to advise of the emergency claim. The Member must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c)

a brief explanation of the emergency; and (d) a description of the attempts to reach his or her PCD. This must be done within 90 days, or as soon as is reasonably possible. We will reimburse the Member for 50% of the cost of the Emergency Dental Services.

Out-Of-Area Emergency Dental Services: If a Member is more than 50 miles from his or her home and Emergency Dental Services are required, he or she may seek care from any Dentist. Then he or she must file a claim within 90 days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating Dentist. The statement must list all services provided. We will reimburse the Member within 30 days for any covered Emergency Dental Services, up to a maximum of $50.00 per incident, after payment of any Patient Charge which may apply.

Grievance Process: There are three stages to the grievance process: (a) the Informal Internal Grievance Process; (b) the Formal Internal Grievance Review Process for standard and expedited reviews; and (c) the External Review.

As used in this section:

"Adverse determination" means a decision by Guardian to deny, reduce or end coverage for: (a) availability of care; or (b) any other dental care services. This decision is made because the service or supply does not meet all the terms of the plan based on: (a) medical necessity; (b) appropriateness; (c) health care setting; (d) level of care; or (e) effectiveness. This decision is based on the review of the information given to Guardian.

"Agency" means the Agency for Health Care Administration of the State of Florida.

"Clinical peer" means a dental care professional in the same or similar specialty who typically manages the medical condition, procedure or treatment under review. But, it does not mean a person who was involved in the initial adverse determination.

"Complaint" means any expression of dissatisfaction by a member that relates to the quality of care given by a provider pursuant to Guardian's contract with that provider. It:

(a) includes dissatisfaction with: (i) the administration; (ii) claims practices; or (iii) provision of services;

(b) may be made to Guardian or to a state agency; and

(c) is part of the informal steps of a grievance process.

"Concurrent review" means a utilization review conducted during a course of treatment.

"Grievance" means a written complaint submitted to Guardian or a state agency by or on behalf of a member regarding these items:

(a) availability, coverage for the delivery, or quality of dental care services, and includes an adverse determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for dental care services; or

(c) matters pertaining to the contractual relationship between a member and Guardian.

Medically necessity means health services, treatment and supplies that are all of the following:

(1) medically appropriate;

(2) needed to Diagnose or treat a Covered Service,

(3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;

(4) needed for reasons other than comfort or convenience of the Member or Dentist;

(5) of proven medical value; and

(6) done with the appropriate level of service or supply needed to provide safe and adequate care.

"Retrospective review" means a review, for coverage purposes, of medical necessity conducted after services have been provided to a patient.

"Urgent grievance" means a grievance where using the standard timeframe of the grievance process would: (a) seriously jeopardize the life or health of a member; or (b) would jeopardize the member's ability to regain maximum function.

"Working day" means Monday through Friday from 9 a.m. to 9 p.m. Eastern Time. It does not include legal holidays.

Informal Internal Grievance Process
A member may make a complaint to Guardian at this address or phone number.

Managed DentalGuard
Quality of Care Liaison
PO Box 4391
Woodland Hills CA 91365
1-888-618-2016

When Guardian receives the initial oral complaint, Guardian will respond to the member or the person acting on his or her behalf within a reasonable time. At the time the complaint is received, Guardian will inform the person making the complaint that he or she:

1. has the right to file a written grievance to the address shown above at any time during the complaint process.
2. must submit the written grievance within one year after the date of the action that caused the grievance.
3. may request Guardian's help in preparing the written grievance.
4. has the right to request an external review to the Statewide Provider and Subscriber Assistance Program panel established by the State of Florida. This may be done after the member has received a final adverse determination through Guardian's internal grievance process. The address and toll free phone number are:

Statewide Provider and Subscriber Assistance Program (SPSAP)
2727 Mahan Drive, Ft. Knox #1
Suite 339
Tallahassee FL 32308
1-888-419-3456

5. has the right, at any time, to inform the Florida Agency for Health Care Administration (the agency) of the grievance at this address or toll free phone number:

   Statewide Provider and Subscriber Assistance Program (SPSAP)
   2727 Mahan Drive, Ft. Knox #1
   Suite 339
   Tallahassee FL 32308
   1-888-419-3456

Formal Internal Grievance Review Process

Standard Review: If a member, or a person acting on his or her behalf, disagrees or is not satisfied with an adverse determination, he or she may request a review of the grievance by an internal review panel. The request must be made within 30 days after Guardian sends the notice of adverse determination.

The majority of persons on the panel will be providers with appropriate expertise. If there has been a denial of coverage of service, the reviewing provider cannot be the same provider who was involved in the initial adverse

determination. The panel may have a person who was previously involved in the adverse determination appear before the panel to give information or to answer questions. Review procedures established by Guardian are available to the member or the provider acting on behalf of the member. Guardian will give the member and the provider, if the provider filed the grievance, a copy of the panel's written decision. The panel has the right to bind Guardian to its decision.

If the internal review process does not resolve the difference of opinion, the member or the provider acting on behalf of the member, may submit a written grievance to the Statewide Provider and Subscriber Assistance Program.

Guardian will resolve a grievance within 60 days of receipt. But if the grievance involves the collection of material outside the service area: (a) the time limit will be 90 days; and (b) if Guardian notifies the member in writing that such information is needed, the time limit is interrupted until the information is received.

Expedited Review: For an urgent grievance, a member, the member's legal representative, or the provider acting on behalf of the member may request an expedited review. The request may be made orally or in writing. Expedited reviews will be made by appropriate clinical peer(s) who were not involved in the initial adverse determination.

Within 24 hours of receiving a request, Guardian will provide reasonable access to a clinical peer who can perform the expedited review.

Guardian will give all necessary information to the member, or the person acting on his or her behalf, by: (a) telephone; (b) fax; or (c) the most expeditious method available. This includes the decision.

Guardian must make a decision and notify the member, or the person acting on his or her behalf. This must be done as soon as possible but not more than 72 hours after receipt of the request. If the initial notice is not in writing, Guardian will provide a written confirmation of that notice within two working days from the initial notice.
If the expedited review is a concurrent review, the service will be continued without liability to the member until the member has received notice of the decision.

Guardian will not provide an expedited retrospective review of an adverse determination.

Right to Notify the State: A member may submit a copy of the grievance to the agency at any time during the internal grievance review process.

Right to an External Review: The final decision letter for a formal grievance review will notify the member of his or her right to an external review by the Statewide Provider and Subscriber Assistance Program, as explained below.

External Review

If a member is not satisfied with the final decision of the formal internal review, he or she may request an external review of that decision by the Statewide Provider and Subscriber Assistance Program. The request for an external review must be made within 365 days after receipt of the final decision letter. It may be made by contacting:

Statewide Provider and Subscriber Assistance Program (SPSAP)
2727 Mahan Drive, Ft. Knox #1
Suite 339
Tallahassee FL 32308
1-888-419-3456

ADDITIONAL CONDITIONS ON COVERED SERVICES

- General Guidelines for Alternative Procedures: There may be a number of accepted methods of treating a specific dental condition. When a Member selects an alternative procedure over the service recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended service and the alternative procedure. He or she will also have to pay the applicable patient charge for the recommended service.

  When the Member selects a posterior composite restoration as an alternative procedure to a recommended amalgam restoration, the alternative procedure policy does not apply.

  When the Member selects an extraction, the alternative procedure does not apply.

  When the PCD recommends a crown, the alternative procedure policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The Member must pay the applicable patient charge for the crown actually placed.

  The Plan provides for the use of noble, high noble and base metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the Member will pay an additional amount for the actual cost of the high noble metal. In addition, the Member will pay the usual patient charge for the inlay, onlay, crown or fixed bridge. The total patient charges for high noble metal may not exceed the actual lab bill for the service.

  In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the Member before treatment begins. The PCD should present the Member with a treatment plan in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

- General Guidelines for Alternative Treatment By The PCD: There may be a number of accepted methods for treating a specific dental condition. In all cases where there are more than one course of treatment available, a full discourse of all the options must be given to the Member before treatment begins. The PCD should present the Member with a written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the Member should pay, and to fully document informed consent.

  - If any of the recommended alternate services are selected by the Member and are not covered under the Plan, then the Member must pay the PCD's usual charge for the recommended alternate service.

  - If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not appropriate service for the condition being treated), then the PCD is not obliged to provide that treatment even if it is a covered service under the Plan.

  - Members can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the PCD or Specialty Care Dentist.

- Crowns, Bridges and Dentures: A crown is a covered service when it is recommended by the PCD. The replacement of a crown or bridge is not covered within 5 years of the original placement under the Plan. The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by reline, rebase or repair. Construction of new dentures may not exceed one each in any 5-year period from the date of previous placement under the Plan. Immediate dentures are not subject to the 5-year limitation.

  The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6

months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture.

Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the PCD.

- Multiple Crown and Bridge Unit Treatment Plan: When a Member's treatment plan includes six (6) or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

- Pediatric Specialty Services: If during a Primary Care Dentist visit, a Member under age eight (8) is unmanageable, the Primary Care Dentist may refer the Member to a Participating Pediatric Specialty Care Dentist for the current treatment plan only. Following completion of the approved pediatric treatment plan, the Member must return to the Primary Care Dentist for further services. If necessary, we must first authorize subsequent referrals to the Participating Specialty Care Dentist. Any services performed by a Pediatric Specialty Care Dentist after the Member's eighth (8^{th}) birthday will not be covered, and the Member will be responsible for the Pediatric Specialty Care Dentist's usual fees.

- Second Opinion Consultation: A Member may wish to consult another dentist for a second opinion regarding services recommended or performed by (a) his or her PCD; or (b) a participating specialty care dentist through an authorized referral. To have a second opinion consultation covered by us, the Member must call or write Member Services for prior authorization. We will only cover a second opinion consultation when the recommended services are otherwise covered under the Plan.

  A Member Services Representative will help the Member identify a participating dentist to perform the second opinion consultation. The Member may request a second opinion with a non-participating general dentist or specialty care dentist. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist. The second opinion consultation shall have the applicable patient charge for code D9310.

  Third opinions are not covered unless requested by us. If a third opinion is requested by the Member, the Member is responsible for the payment. Exceptions will be considered on an individual basis, and must be approved in writing by us.

  The Plan's benefit for a second opinion consultation is limited to $50.00. If a participating dentist is the consultant dentist, the Member is responsible for the applicable patient charge for code D9310. If a non-participating dentist is the consultant dentist, the Member must pay the applicable patient charge for code D9310 and any portion of the dentist's fee over $50.00.

- Noble and High Noble Metals: The Plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the Member will be responsible for the Patient Charge for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

  General anesthesia / IV sedation / Nitrous oxide / Non-intravenous conscious sedation – General anesthesia / IV sedation / Nitrous oxide / Non-intravenous conscious sedation is limited to services provided by a Participating Oral Surgery Specialty Care Dentist. Not all Participating Oral Surgery Specialty Care Dentists offer these services. The Member is responsible to identify and receive services from a Participating Oral Surgery Specialty Care Dentist willing to provide general anesthesia or IV sedation. The Member's Patient Charge is shown in the Covered Dental Services and Patient Charges section.

ORTHODONTIC TREATMENT

- The Plan covers orthodontic services as listed under Covered Dental Services and Patient Charges. Limited to one course of treatment per Member. We must preauthorize treatment, and treatment must be performed by a Participating Orthodontic Specialty Care Dentist.

- The Plan covers up to twenty-four (24) months of comprehensive orthodontic treatment. If treatment beyond twenty-four (24) months is necessary, the Member will be responsible for each additional month of treatment, based upon the Participating Orthodontic Specialty Care Dentist's contracted fee.

- Except as described under the Treatment in Progress—Orthodontic Treatment section, orthodontic services are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Plan. If a Member's coverage terminates after the fixed banding appliances are inserted, the Participating Orthodontic Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the Participating Orthodontic Specialty Care Dentist for services after the termination date. Retention services are covered at the Patient Charge shown in the Plan Schedule's section only following a course of comprehensive orthodontic treatment started and completed under this Plan.

- If a Member transfers to another Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member will be responsible for any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

- The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility. The benefit for orthodontic retention is limited to twelve (12) months and covers any and all necessary fixed and removable appliances and related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the Plan. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

- The Plan does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the Member's responsibility.

- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialist Dentist's usual fee.

TREATMENT IN PROGRESS

- Treatment in progress: Restorative Treatment – Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are listed as Covered Services and were started but not completed prior to the Member's eligibility to receive benefits under this Plan, have a Patient Charge equal to 85% of the Participating General Dentist's usual fee (there is no additional charge for high noble metal).

- Treatment in progress: Endodontic Treatment – Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are listed on the Member's Plan Schedule that were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a

Participating General or Specialty Care Dentist who is willing to complete the procedure at a patient charge equal to 85% of Participating Dentist's usual fee.

- Treatment in progress: Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are listed on the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment, including retention, at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee.

LIMITATIONS AND EXCLUSIONS

Limitations:

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) – a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D1208, D2999) – four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.
- Full mouth x-rays – one (1) set in any three (3) year period.
- Bitewing x-rays – two (2) sets in any twelve (12) month period.
- Panoramic x-rays – one (1) in any three (3) year period.
- Sealants – limited to permanent teeth, up to the 16th birthday – one (1) per tooth in any three (3) year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) – a total of one (1) service per quadrant or area in any three (3) year period.
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
- Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
- Cleft palate treatment, cancer treatment, and biopsies may also fall under medical services.
- Treatment of fractures may also fall under medical services where the treatment is due to an accident or injury to the mouth.
- Inpatient hospital services may also fall under medical services and be covered through the separate medical services contract depending on the treatment needed and the nature of the injury.
- Emergency dental services when more than fifty (50) miles from the Primary Care Dentist's office – limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by MDG – limited to the benefit for palliative treatment (D9110) only.
- Reline of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Rebase of a complete or partial denture – one (1) per denture in any twelve (12) month period.

- Second Opinion Consultation – when approved by the Plan, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan.

Exclusions – We will not cover:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.

- Dental services performed in a hospital, surgical center, or related hospital fees.

- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise Covered Service involving (a) congenitally missing or (b) supernumerary teeth.

- Any histopathological examination or other laboratory charges.

- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.

- Any oral surgery requiring the setting of a fracture or dislocation.

- Placement of osseous (bone) grafts.

- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.

- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the Participating Dentist is not necessary for maintaining or improving the Member's dental health, or (b) which is solely for cosmetic purposes.

- Precision attachments, stress breakers, magnetic retention or overdenture attachments.

- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.

- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.

- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.

- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.

- Any Member request for: (a) specialist services or treatment which can be routinely provided by the Primary Care Dentist, or (b) treatment by a specialist without a referral from the Primary Care Dentist and Plan approval.

- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons (d) realign teeth.

- Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

- Dental services, other than covered Emergency Dental Services, which were performed by any dentist other than the Member's selected and assigned Primary Care Dentist, unless we had provided written authorization.

- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

- Treatment which requires the services of a Prosthodontist.

- Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th (eighth) birthday.

- Consultations for non-covered services.

- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.

- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.

- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.)

- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)

- Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Inlays, onlays, crowns, or fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the Plan as Emergency Dental Services.

- Root canal treatment started by a non-participating dentist. (Root canal treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the Plan as Emergency Dental Services.

- Orthodontic treatment started by a non-participating dentist while the Member is covered under this Plan. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Extractions performed solely to facilitate orthodontic treatment.

- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.

- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.

- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.

- Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.

- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.

- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

DEFINITIONS

Alternative Procedure means a procedure other than that recommended by the Member's Primary Care Dentist, but which in the opinion of the Primary Care Dentist also represents an acceptable treatment approach for the Member's dental condition.

Dentist means any dental practitioner who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this Plan.

Dependent means a person who is:

(1) Your spouse; or

(2) Your Dependent Child or Your Spouse's dependent child who is less than 26 years of age;

The term "Dependent" as used herein will include your spouse and any stepchild, newborn child, legally adopted child, a child for whom you are the court-appointed legal guardian, or a proposed adoptive child during any waiting period prior to the formal adoption if the child is a part of your household and is primarily dependent on you for support and maintenance. The term also includes any child for whom a court-ordered decree requires you to provide Dependent coverage.

The term "Dependent" will also include an intellectually disabled or physically handicapped Dependent Child who: (1) has reached the upper age limit of a Dependent Child; (2) is not capable of self-sustaining work; and (3) depends primarily on You for support and maintenance. You must furnish proof of such lack of capacity and dependence to Us within 31 days after the child reaches the limiting age, and each year after that, if requested by Us

The term "Dependent" also includes any newborn or legally adopted child of your child, if your child is considered a "Dependent" under this Plan.

Emergency Dental Services mean only covered, bona fide emergency services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort, or to prevent the imminent loss of teeth. Services related to the initial emergency condition but not required specifically to relieve pain, discomfort, bleeding or swelling or to prevent imminent tooth loss, including services performed at the emergency visit and services performed at subsequent visits, are not considered Emergency Dental Services.

Managed DentalGuard (MDG) means the network of Participating Dentists associated with this Plan.

Member means You and any of Your eligible Dependents, as defined under the eligibility requirements of this Plan, who are actually enrolled in and eligible to receive benefits under this Plan.

Non-Participating Dentist means any Dentist that is not under contract with The Guardian to provide services to Members.

Participating Dentist means a licensed Dentist under contract with The Guardian and shall include any hygienists and technicians recognized by the dental profession who assist and act under the supervision of a Participating Dentist.

Participating General Dentist means a licensed Dentist under contract with The Guardian who is listed in The Guardian's directory of Participating Dentists as a general practice Dentist, and who may be selected as a Primary Care Dentist by a Member to provide or arrange for a Member's dental services.

Participating Specialist Dentist means a licensed Dentist under contract with The Guardian as an Endodontist, Pediatric Specialist Dentist, Periodontist, Oral Surgeon or Orthodontist.

Patient Charge means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this Plan, which represents the patient's portion of the cost of covered dental procedures.

Plan means The Guardian Individual Plan for Dental Services described herein.

Primary Care Dentist means a Participating General Dentist, selected by a Member, who is responsible for providing and arranging for a Member's dental services.

Service Area means the geographic area in which The Guardian has arranged to provide for dental services for Members.

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

You, Your or Planowner means the Planowner who purchased this Plan.

TECHNICAL DENTAL TERMS

ABSCESS
acute or chronic, localized inflammation, with a collection of pus, associated with tissue destruction and, frequently, swelling.

ABUTMENT
a tooth used to support a prosthesis.

ALVEOLAR
referring to the bone to which a tooth is attached.

ALVEOLOPLASTY
surgical procedure for recontouring alveolar structures, usually in preparation for a prosthesis.

AMALGAM
an alloy used in direct dental restorations.

ANALGESIA
loss of pain sensations without loss of consciousness.

ANESTHESIA
partial or total absence of sensation to stimuli.

ANTERIOR
refers to the teeth and tissues located towards the front of the mouth - maxillary and mandibular incisors and canines.

APEX
the tip or end of the root end of the tooth.

APICOECTOMY
amputation of the apex of a tooth.

BICUSPID
a premolar tooth; a tooth with two cusps.

BILATERAL
occurring on, or pertaining to, both sides.

BIOPSY
process of removing tissue for histologic evaluation.

BITEWING RADIOGRAPH
interproximal view radiograph of the coronal portion of the tooth.

BRIDGE
a fixed partial denture (fixed bridge) is a prosthetic replacement of one or more missing teeth cemented or attached to the abutment teeth.

CANAL
space inside the root portion of a tooth containing pulp tissue

CARIES
commonly used term for tooth decay.

CAVITY
decay in tooth caused by caries; also referred to as carious lesion.

CEPHALOMETRIC RADIOGRAPH
a radiographic head film utilized in the scientific study of the measurements of the head with relation to specific reference points.

COMPOSITE
a tooth-colored dental restorative material

CROWN
restoration covering or replacing the major part, or the whole of the clinical crown -(i.e., that portion of a tooth not covered by supporting tissues.)

CROWN LENGTHENING
a surgical procedure exposing more tooth for restorative purposes by apically positioning the gingival margin and removing supporting bone.

CYST
pathological cavity, containing fluid or soft matter.

DEBRIDEMENT
removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an evaluation.

DECAY
the lay term for carious lesions in a tooth; decomposition of tooth structure.

DENTURE
an artificial substitute for natural teeth and adjacent tissues.

DENTURE BASE
that part of a denture that makes contact with soft tissue and retains the artificial teeth.

DIAGNOSTIC CAST
plaster or stone model of teeth and adjoining tissues; also referred to as study model.

DISTAL
toward the back of the dental arch (or away from the midline).

ENDODONTIST
a dental specialist who limits his/her practice to treating disease and injuries of the pulp (root canal therapy) and associated periradicular conditions.

EVULSION
separation of the tooth from its socket due to trauma.

EXCISION
surgical removal of bone or tissue.

EXOSTOSIS
overgrowth of bone.

EXTRAORAL
outside the oral cavity.

FRENULECTOMY
excision of muscle fibers covered by a mucous membrane that attaches the cheek, lips and or tongue to associated dental mucosa.

GINGIVA
soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted, serving as the supporting structure for sub-adjacent tissues.

GINGIVAL CURETTAGE
the surgical procedure of scraping or cleaning the walls of a gingival pocket.

GINGIVECTOMY
the excision or removal of gingiva.

GINGIVOPLASTY
surgical procedure to reshape gingiva to create a normal, functional form.

HEMISECTION
surgical separation of a multirooted tooth so that one root and/or the overlaying portion of the crown can be surgically removed.

HISTOPATHOLOGY
the study of composition and function of tissues under pathological conditions.

IMMEDIATE DENTURE
removable prosthesis constructed for placement immediately after removal of remaining natural teeth.

IMPACTED TOOTH
an unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.

IMPLANT
material inserted or grafted into tissue; dental implant - device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement

INCISAL ANGLE
one of the angles formed by the junction of the incisal and the mesial or distal surfaces of an anterior tooth.

INLAY
an intracoronal restoration; a dental restoration made outside of the oral cavity to correspond to the form of the prepared cavity, which is then cemented into the tooth.

INTERCEPTIVE ORTHODONTIC TREATMENT
an extension of preventive orthodontics that may include localized tooth movement in otherwise normal dentition.

INTERIM PARTIAL DENTURE
a provisional removable prosthesis designed for use over a limited period of time, after which it is to be replaced by a more definitive restoration.

INTRAORAL
inside the mouth.

LABIAL
pertaining to or around the lip.

LIMITED ORTHODONTIC TREATMENT
orthodontic treatment with a limited objective, not involving the entire dentition

LINGUAL
pertaining to or around the tongue.

MESIAL
toward the midline of the dental arch.

METALS, CLASSIFICATION OF
The noble metal classification system is defined on the basis of the percentage of noble metal content: high noble - Gold (Au), Palladium (Pd), and/or Platinum (Pt) greater than 60% (with at least 40% Au); noble – Gold (Au), Palladium (Pd), and/or Platinum (Pt) greater than 25%; and predominantly base - Gold (Au), Palladium (Pd), and/or Platinum (Pt) less than 25%.

MOLAR
teeth posterior to the premolars (bicuspids) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.

OCCLUSAL ADJUSTMENT, LIMITED
reshaping of the occlusal surfaces of teeth to create harmonious contact relationships between the upper and lower teeth; typically on a "per visit" basis.

OCCLUSAL RADIOGRAPH
an intraoral radiograph made with the film being held between the occluded teeth.

OCCLUSION
any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

ONLAY
a restoration made outside the oral cavity that replaces a cusp or cusps of the tooth, which is then cemented to the tooth.

ORAL SURGEON
a dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases of the oral regions.

ORTHODONTIST
a dental specialist whose practice is limited to the treatment of malocclusion of the teeth

ORTHOGNATHIC
functional relationship of maxilla and mandible.

OVERDENTURE
prosthetic device that is supported by retained teeth roots.

PALLIATIVE
action that relieves pain but is not curative.

PANORAMIC RADIOGRAPH
an extraoral radiograph on which the maxilla and mandible are depicted on a single film.

PARTIAL DENTURE, REMOVABLE
a prosthetic replacement of one or more missing teeth on a framework that can be removed by the patient.

PEDIATRIC DENTIST

a dental specialist whose practice is limited to treatment of children

PERIAPICAL
the area surrounding the end of the tooth root.

PERIODONTAL
pertaining to the supporting and surrounding tissues of the teeth.

PERIODONTAL DISEASE
inflammatory process of the gingival tissues and/or periodontal membrane of the teeth, resulting in an abnormally deep gingival sulcus, possibly producing periodontal pockets and loss of supporting alveolar bone.

PERIODONTIST
a dental specialist whose practice is limited to the treatment of periodontal diseases.

PERIRADICULAR
surrounding a portion of the root of the tooth.

PONTIC
the term used for the artificial tooth on a fixed bridge.

POST
an elongated metallic projection fitted and cemented within the prepared root canal, serving to strengthen and retain restorative material and/or a crown restoration.

POSTERIOR
refers to teeth and tissues towards the back of the mouth (distal to the canines) - maxillary and mandibular premolars and molars.

PRECISION ATTACHMENT
interlocking device, one component of which is fixed to an abutment or abutments and the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it.

PREMOLAR
see bicuspid.

PRIMARY DENTITION
the first set of teeth.

PROPHYLAXIS
scaling and polishing procedure performed to remove coronal plaque, calculus and stains.

PROSTHESIS, DENTAL
any device or appliance replacing one or more missing teeth and/or, if required, certain associated structures.

PROSTHODONTIST
a dental specialist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.

PULP
the blood vessels and nerve tissue that occupies the pulp chamber of a tooth.

PULP CAP
procedure in which the exposed or nearly exposed pulp is covered with a protective dressing or cement to maintain pulp vitality and/or protect the pulp from additional injury

PULP CHAMBER
the space within a tooth which contains the pulp.

PULPOTOMY
surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.

QUADRANT
one of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth.

RADIOGRAPH
x-ray.

REBASE
process of refitting a denture by replacing the base material.

REIMPLANTATION, TOOTH
the return of a tooth to its alveolus.

RELINE
process of resurfacing the tissue side of a denture with new base material.

RETENTION
the phase of orthodontics used to stabilize teeth following comprehensive orthodontic treatment.

RETROGRADE FILLING
a method of sealing the root canal by preparing and filling it from the root apex.

ROOT
the anatomic portion of the tooth that is located in the alveolus (socket) where it is attached by the periodontal apparatus.

ROOT CANAL
the portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.

ROOT CANAL THERAPY
the treatment of disease and injuries of the pulp and associated periradicular conditions.

ROOT PLANING
a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased tooth structure on the root surfaces and in the pocket.

SCALING
removal of plaque, calculus, and stain from teeth.

SPLINT
a device used to support, protect, or immobilize oral structures that have been loosened, replanted, fractured or traumatized.

STRESS BREAKER
that part of a tooth-borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.

STUDY MODEL

plaster or stone model of teeth and adjoining tissues; also referred to as diagnostic cast.

TEMPOROMANDIBULAR JOINT (TMJ)
the connecting hinge mechanism between the mandible (lower jaw) and base of the skull (temporal bone).

TISSUE CONDITIONING
material intended to be placed in contact with tissues, for a limited period, with the aim of assisting their return to healthy condition.

UNERUPTED
tooth/teeth that have not penetrated into the oral cavity.

UNILATERAL
one-sided; pertaining to or affecting but one side.

VENEER
in the construction of crowns or pontics, a layer of tooth-colored material, usually, but not limited to, composite, porcelain, ceramic or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention; also refers to a restoration that is cemented to the tooth.

The Guardian Life Insurance Company of America
Limited Benefit Health Coverage – Dental
Outline of Coverage
7 Hanover Square
New York, New York 10004
IP-MDG-DHMO-OOC-FL-16

(1) This Outline of Coverage describes a Limited Benefit Health Coverage for Dental.

(2) **The services covered by the plan are named in the list of Covered Dental Services and Patient Charges. If a service, treatment or procedure is not on that list, it is not a covered service. All services must be provided by the assigned Primary Care Dentist (PCD).**

The Member must pay the listed Patient Charge. The benefits Guardian provides are subject to all of the terms of the plan, including the Limitations and Conditions on Covered Dental Services and Exclusions.

There is a limit on the total amount of Patient Charges a Member who is under age 19 must pay each calendar year for pediatric essential health benefits as determined by Florida. The limit is $350.00 for each such Member. Once this limit is reached the plan waives Patient Charges for such benefits for the rest of the calendar year for such Member. But if two or more such Members meet the limit of $700.00 in a calendar year, the plan waives the Patient Charges for such benefits for all other such Members for the rest of the calendar year.

The Patient Charges listed the in the Covered Dental Services and Patient Charges section are only valid for covered services that are: (1) started and completed under the plan, and (2) rendered by Participating Dentists in the State of Florida.

We cover the pediatric dental care services for Members through the end of the month in which the Members turn 19 years of age.

(3) **Exclusions**:

The plan will not cover:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise Covered Service involving (a) congenitally missing or (b) supernumerary teeth.
- Any histopathological examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.

- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the Participating Dentist is not necessary for maintaining or improving the Member's dental health, or (b) which is solely for cosmetic purposes.

- Precision attachments, stress breakers, magnetic retention or overdenture attachments.

- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.

- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.

- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.

- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.

- Any Member request for: (a) specialist services or treatment which can be routinely provided by the Primary Care Dentist, or (b) treatment by a specialist without a referral from the Primary Care Dentist and Plan approval.

- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons (d) realign teeth.

- Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

- Dental services, other than covered Emergency Dental Services, which were performed by any dentist other than the Member's selected and assigned Primary Care Dentist, unless we had provided written authorization.

- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

- Treatment which requires the services of a Prosthodontist.

- Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th (eighth) birthday.

- Consultations for non-covered services.

- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.

- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.

- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken, and (b) completed when the denture is delivered to the member.)

- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)

- Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Inlays, onlays, crowns, or fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the plan as Emergency Dental Services.

- Root canal treatment started by a non-participating dentist. (Root canal treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the plan as Emergency Dental Services.

- Orthodontic treatment started by a non-participating dentist while the Member is covered under the plan. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Extractions performed solely to facilitate orthodontic treatment.

- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.

- Orthognathic surgery (moving of teeth by surgical means) and associated

incremental charges.

- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.

- Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.

- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.

- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

Limitations:

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) – a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D1208, D2999) – four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.
- Full mouth x-rays – one (1) set in any three (3) year period.
- Bitewing x-rays – two (2) sets in any twelve (12) month period.
- Panoramic x-rays – one (1) in any three (3) year period.
- Sealants – limited to permanent teeth, up to the 16th birthday – one (1) per tooth in any three (3) year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) –

a total of one (1) service per quadrant or area in any three (3) year period.

- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
- Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
- Cleft palate treatment, cancer treatment, and biopsies may also fall under medical services.
- Treatment of fractures may also fall under medical services where the treatment is due to an accident or injury to the mouth.
- Inpatient hospital services may also fall under medical services and be covered through the separate medical services contract depending on the treatment needed and the nature of the injury.
- Emergency dental services when more than fifty (50) miles from the Primary Care Dentist's office – limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the member's assigned PCD, and without referral by the PCD or authorization by MDG – limited to the benefit for palliative treatment (D9110) only.
- Reline of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Rebase of a complete or partial denture – one (1) per denture in any twelve (12) month period.
- Second Opinion Consultation – when approved by the Plan, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan.

(4) **Renewal At The Option Of The Company**

The plan is conditionally renewable and will continue in effect as long as the premiums are paid when they are due or within the grace period in accordance with the terms and conditions of the plan.

The plan may be renewed for a further term by timely payment of renewal, unless Guardian sends prior notice of its intention not to renew. If Guardian does refuse to renew Guardian must do so on all policies of this form issued under the same class in the state. At least 60 days prior to the premium due date, Guardian will send written notice of non-renewal to the last known address shown on record. Non-renewal will not affect any otherwise valid claim that starts while the plan is in force.

(5) This Outline of Coverage contains only a summary of the details of the plan as applied for and that the issued plan should be referred to for the actual contractual governing provisions.

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AVISO IMPORTANTE SOBRE LA ASISTENCIA DE IDIOMA Y DISCRIMINACIÓN

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Arabic العربية	إذا كنت أنت أو الشخص الذي يساعد ديه أسئلة حول فوائد التأمين والمطالبات، أو تغطية، لديك الحق في الحصول على المساعدة والمعلومات في لغتك دون أي تكلفة. التحدث الى مترجم: إذا كان لديك التأمين من صاحب العمل الخاص بك، الاتصال على رقم الهاتف على بطاقة الهوية الخاصة بك. لجميع الأعضاء، يرجى الاتصال 844-561-5600. الجارديان والشركات التابعة لها * الالتزام بالقوانين الاتحادية المطبقة الحقوق المدنية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة، أو الجنس..
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Armenian **Հայերեն**	Եթե դուք կամ այն անձը, դուք օգնում ունի հարցեր ձեր ապահովագրական հատուցումներից, պահանջների, կամ լուսաբանման, դուք իրավունք ունեք ստանալու օգնություն եւ տեղեկատվություն Ձեր լեզվով ոչ մի գնով: Խոսել է թարգմանչի: Եթե ունեք ապահովագրություն Ձեր գործատուի, զանգահարեք հեռախոսահամարը Ձեր նույնականացման քարտ. բոլոր մյուս անդամների համար, խնդրում ենք զանգահարել 844-561-5600. The Guardian եւ իր դուստր ձեռնարկություններն * համապատասխանեն կիրառելի դաշնային քաղաքացիական իրավունքների օրենքների եւ չի խտրականություն հիման վրա ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի, հաշմանդամության, կամ սեռից:
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