

The Guardian Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
7 Hanover Square, New York, New York 10004

SCHEDULE OF BENEFITS

This plan includes BOTH Pediatric Dental Essential Health Benefits and Non-Pediatric Dental Benefits. The benefits and limitations for the Pediatric Dental Essential Health Benefits are substantially equal to those covered in the FEDVIP Benchmark Dental Plan, as identified by the Federal Government.

The Policy refers to various dollar and percentage amounts, as well as other benefit information that may be specific to Pediatric Dental Benefits. This Schedule summarizes benefit information and the date these benefits take effect. You selected some of these benefits when You applied for this Policy. As Your needs change over the time You own this Policy, You may change some of these benefits without replacing or purchasing a new Policy. Some of the provisions of this Policy require automatic changes. For example, when a Dependent no longer qualifies for coverage under this Policy due to their age, that Dependent's coverage will terminate.

Please read the entire Policy, along with this Schedule of Benefits, to fully understand all terms, conditions, limitations and exclusions that apply.

POLICYOWNER	Refer to Your ID Card
POLICY NUMBER	Refer to Your ID Card
EFFECTIVE DATE	The Effective Date Approved by Us
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.

NOTICE: Your actual expenses for covered services may exceed the stated coinsurance percentage because actual provider charges may not be used to determine Plan and Covered Person payment obligations.

NON-PEDIATRIC DENTAL SCHEDULE

Deductible Information

Deductible per Insured per Benefit Year

(When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.)

Preferred Provider Benefit Year Deductible:

Group I, Group II and Group III Services\$75.00

Non-Preferred Provider Benefit Year Deductible:

Group I, Group II and Group III Services\$150.00

Payment Rates

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

Preferred Provider Payment Rate for:

Group I Services	100%
Group II Services	60%
Group III Services	50%
Group IV (Orthodontic) Services	0%

Non-Preferred Provider Payment Rate for:

Group I Services	70%
Group II Services	40%
Group III Services	30%
Group IV (Orthodontic) Services	0%

Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximum

Annual Maximum per Covered Person	\$800.00
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Preferred Provider and Non-Preferred Provider Waiting Periods

Group I Services	None
Group II Services	6 Months
Group III Services	12 Months

PEDIATRIC DENTAL SCHEDULE FOR COVERED PERSONS UNDER AGE 19

The following schedule information applies to Covered Persons who are eligible for the Pediatric Dental Services explained below until the end of the month in which they turn 19 years of age.

Pediatric Dental Services Deductible Information

Deductible per Insured Child per Benefit Year

Preferred Provider Benefit Year Deductible:

Group I, Group II and Group III Services	\$75.00
Group IV (Orthodontic) Services	None

Non-Preferred Provider Benefit Year Deductible:

Group I, Group II and Group III Services	\$150.00
Group IV (Orthodontic) Services	None

Pediatric Dental Services Payment Rates

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

Preferred Provider Payment Rates:

Group I Services	100%
Group II Services	50%
Group III Services	50%
Group IV (Orthodontic) Services	50%

Non-Preferred Provider Payment Rates:

Group I Services	90%
Group II Services	40%
Group III Services	40%
Group IV (Orthodontic) Services	30%

Emergency Service Payment Rates:

Group I Services	100%
Group II Services	50%
Group III Services	50%
Group IV (Orthodontic) Services	50%

Pediatric Dental Services Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximums:

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

Preferred Provider and Non-Preferred Provider Orthodontics Lifetime Maximum None

Preferred Provider Out of Pocket Annual Maximum Per Insured Child\$350.00

Preferred Provider Out of Pocket Annual Maximum For Two or More Insured Children\$700.00

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

Non-Preferred Provider Out of Pocket Annual Maximum None

Preferred Provider and Non-Preferred Provider Waiting Periods:

Group I, Group II, Group III and Group IV (Orthodontics) ServicesNone

If a network general or specialist dentist is unavailable and the member has no option but to receive medically necessary covered treatment from a non-network general or specialist dentist, Guardian will be available to assist a member in identifying a non-network general or specialist dentist and will arrange for reimbursement at the in-network rate. In-network reimbursement of treatment performed by a non-network general or specialist dentist will be limited to covered medically necessary dental services.

A general or specialist dentist will be considered unavailable when one of the following applies:

1. A general or specialist dentist is not located: a) within fifteen (15) miles of a member's home or place of employment in an urban service area; b) within forty-five (45) miles of a member's

home or place of employment in an suburban service area, or c) within seventy-five (75) miles of a member's home or place of employment in a rural service area; or

2. The member is not able to obtain; a) a routine care appointment within two (2) weeks of a member's request; or b) a preventive care appointment within thirty (30) days of a member's request.

Guardian will verify information related to the notification from the member that a network general or specialist dentist was not available within the above stated appointment timeframes or the required driving distance in accordance with the treatment submitted and the treating dentist seen. The information verified may include, but may not be limited to, review of the network general and specialist dentists available within the required driving distance from the member's home or place of employment. A review of the network general or specialist dentists that the member attempted to obtain an appointment with may include, but may not be limited to, a discussion with the dentist regarding appointment availability.

In-network reimbursement of emergency treatment performed by a non-network general or specialist dentist will be provided when medically necessary dental services are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth. Prior authorization of services is not required and these services will be reimbursed at an in-network rate.

How It Works

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

The dental PPO is made up of Preferred Providers in a Covered Person's geographic area. Use of the dental PPO is voluntary. A Covered Person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers at any time. When You enroll in this Policy, You and Your covered dependents receive: (1) a dental insurance ID card; and (2) a list of all participating providers. The list is available electronically through the website shown on the plan ID card or in printed paper copy available by contacting us at the address or telephone number shown below.

This Policy usually pays a higher level of benefits for covered treatment furnished by a Preferred Provider. Conversely, it usually pays less for covered treatment furnished by a Non-Preferred Provider. For example, a covered service with a covered charge of \$200.00 will be paid as follows, considering there is no deductible or the deductible has already been met:

Service Performed By:	Payment Rate	Payment Amount
Preferred Provider	100%	\$200.00
Non- Preferred Provider	90%	\$180.00
(for services of a Non-Preferred Provider, the covered person may be responsible for any charge due over the payment amount.)		

Basic

Preferred Provider	50%	\$62.50
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(\$200 - \$75 deductible = \$125 at 50% = \$62.50)

Non- Preferred Provider	40%	\$20.00
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(\$200 - \$150 deductible = \$50 at 40% = \$20)

Major

Preferred Provider	50%	\$62.50
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(\$200 - \$75 deductible = \$125 at 50% = \$62.50)

Non- Preferred Provider	40%	\$20.00
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(\$200 - \$150 deductible = \$50 at 40% = \$20)

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

What We pay is based on all of the terms of this Policy. Please read this Policy carefully.

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

Please review the coverage, exclusions and limitations. Some services require prior authorization.

Covered charges are the charges listed in the applicable fee schedule the Preferred Provider Dentist has agreed to accept as payment in full, for the dental services included in the List of Covered Dental Services below.

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

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

How to Reach Us

Claim Dept. P O Box 981587 El Paso, TX 79998-1587	Member Services Line (844) 561-5600	On the Web dentalexchange.guardianlife.com
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NON-PEDIATRIC DENTAL SERVICES

List Of Covered Non-Pediatric Dental Services

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

Group I Services (Diagnostic & Preventive)

Prophylaxis and Fluorides

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

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

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

Office Visits, Evaluations and Examination

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

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

Space Maintainers

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

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

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

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

Fixed and Removable Appliances

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

Radiographs

Allowance includes evaluation and diagnosis.

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

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

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

Intraoral periapical or occlusal images- single images.

Dental Sealants

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

Group II Services (Basic)

Restorative Services

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

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

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

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

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

Diagnostic Services

Allowance includes examination and diagnosis.

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

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

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

Periodontal Services

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

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

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

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

Periodontal Surgery

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

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

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

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

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

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

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

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

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

Periodontal Surgery Related

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

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

Non-Surgical Extractions

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

Uncomplicated extraction, one or more teeth.

Root removal, non-surgical extraction of exposed roots.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

Group III Services (Major)

Group III Restorative Services

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

Single Crowns:

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

Inlays.

Onlays, including inlay.

Labial veneers.

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

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

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

- Abutment supported crown.
- Implant supported crown.
- Abutment supported retainer for fixed partial denture.

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

Prosthodontic Services

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

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

Bridge abutments:

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

Bridge Pontics:

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

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

Complete or immediate dentures, upper or lower.

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

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

- Removable unilateral partial, one piece cast metal, including clasps and teeth.

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

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

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

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

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

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

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

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

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

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

Endodontic Services

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

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

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

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

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

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

Surgical Extractions

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

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

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

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

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Biopsy and examination of tooth related oral tissue.

Brush biopsy

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of tooth related tumors, cysts and neoplasms.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Sialolithotomy.

Sialodochoplasty.

Closure of salivary fistula. Excision of salivary gland.

Maxillary sinusotomy for removal of tooth fragment or foreign body.

Vestibuloplasty.

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, nitrous oxide, when administered in connection with covered

periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under Other Surgical Procedures.

Waiting Periods For Certain Services

The following services when furnished by a Preferred Provider or Non-Preferred Provider are not considered covered charges during the waiting period shown in the Schedule of Benefits:

Group II Services

Group III Services

The services shown above are not covered charges under this Policy, and cannot be used to meet this Policy's Deductibles.

Limitations

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

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition requiring services or supplies for the treatment of an Occupational Injury or Sickness which are payable under the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers' Compensation Act.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for a specific cosmetic services. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least ten years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.

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

PEDIATRIC DENTAL SERVICES FOR COVERED PERSONS UNDER AGE 19

List Of Covered Pediatric Dental Services

The list below provides the required Pediatric Dental Services until the end of the month in which the Covered Person turns 19 years of age.

Group I Services (Diagnostic & Preventive)

Prophylaxis and Fluorides

Prophylaxis: Limited to a total of one prophylaxis in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains.

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

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

Office Visits, Evaluations and Examination

All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period.

After-hours office visit or emergency palliative treatment.

Space Maintainers

Space Maintainers: Covered only when necessary to replace prematurely lost or extracted deciduous teeth.

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

Recementation of space maintainer.

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth series, of at least 14 images including bitewings, limited to one in any 60 consecutive month period.

Panoramic image, maxilla and mandible, with or without bitewing radiographs, limited to one in any 60 consecutive month period.

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

Intraoral periapical or occlusal images- single images.

Dental Sealants

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

Group II Services (Basic)

Restorative Services

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

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

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

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

Diagnostic Services

Allowance includes examination and diagnosis.

Consultations: Diagnostic consultation with a Dentist other than the one providing treatment.

Diagnostic casts.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

Group III Services (Major)

Group III Restorative Services

Crowns, inlays, onlays, labial veneers and crown buildups are covered only when needed because of decay or Injury, and only when the tooth cannot be restored with amalgam or resin based composite filling material. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations.

Single Crowns:

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

Inlays.

Onlays, including inlay.

Labial veneers.

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

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

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

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

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

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

Other implant services:

- Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site.
- Radiographs/surgical implant index: Limited to once per arch in any 60 month period.
- Repair implant supported prosthesis.
- Repair implant abutment.
- Implant removal.

Prosthodontic Services

Specialized techniques and characterizations are not covered. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also, see the Exclusions.

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

Bridge abutments:

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

Bridge Pontics:

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

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

Complete or immediate dentures, upper or lower.

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

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

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

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

Recementation.

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

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

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

Denture rebase, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase is done by the Dentist who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.

Denture reline, full or partial denture: Limited to once per denture in any 36 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the reline is done by the Dentist who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.

Denture adjustments.

Tissue conditioning.

Other Services

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

Detailed and extensive oral evaluations – problem focused, by report

Endodontic Services

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

Pulp capping.

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

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

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

Root canal treatment

Root canal retreatment.

Treatment of root canal obstruction, no surgical access.

Incomplete endodontic therapy, inoperable or fractured tooth.

Internal root repair of perforation defects.

Apexification.

Apicoectomy.

Root amputation.

Retrograde filling.

Hemisection, including any root removal.

Periodontal Services

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

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

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

Full mouth debridement: Limited to once per lifetime.

Periodontal Surgery

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

Gingivectomy or gingivoplasty, per tooth (less than three teeth), once in any 36 consecutive month period.

Crown lengthening, hard tissue.

Gingivectomy or gingivoplasty, per quadrant, once in any 36 consecutive month period.

Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant, once in any 36 consecutive month period.

Gingival flap procedure, including scaling and root planing, per quadrant, once in any 36 consecutive month period.

Distal or proximal wedge procedure, not in conjunction with osseous surgery, once in any 36 consecutive month period.

Surgical revision procedure, per tooth, once in any 36 consecutive month period.

Pedicle or free soft tissue grafts, including donor site.

Subepithelial connective tissue graft procedure.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier, once in any 36 consecutive month period, limited to when the tooth is present.

Bone replacement grafts, once in any 36 consecutive month period, limited to when the tooth is present.

Periodontal Surgery Related

Occlusal guards: limited to one in a 12 consecutive month period.

Non-Surgical Extractions

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

Uncomplicated extraction, one or more teeth.

Root removal, non-surgical extraction of exposed roots.

Surgical Extractions

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

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

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

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

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Vestibuloplasty.

Tooth reimplantation.

Group IV Services (Orthodontics)

Orthodontic Services

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

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

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

Treatment Plan

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

How We Pay Benefits for Orthodontic Services

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

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

We don't pay for orthodontic charges incurred by a Covered Person prior to being covered by this plan. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this plan to charges determined to be incurred by the Covered Person while covered

by this Plan. Based on the original treatment Plan, We determine the portion of charges incurred by the Covered Person prior to being covered by this Plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

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

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

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

Exclusions

The Exclusions listed here apply to Covered Persons under the age of 19.

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons. Excluded cosmetic services include but are not limited to: (1) characterization and personalization of a Dental Prosthesis; and (2) odontoplasty.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.
- Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 60 months old; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable.
- Any procedure, Appliance, Dental Prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Educational services, including, but not limited to: (1) oral hygiene instruction; (2) plaque control; (3) tobacco counseling; or (4) diet instruction.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Any restoration, procedure, Appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- Bite registration or bite analysis.
- Precision attachments and the replacement of part of a: (1) precision attachment; or (2) magnetic retention or overdenture attachment.
- Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
- The replacement of extracted or missing third molars/wisdom teeth.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- Any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Temporary or provisional Dental Prosthesis or Appliances except interim partial dentures/stayplates to replace Anterior Teeth extracted while covered under this Plan.
- The use of local anesthetic other than as outlined under the List of Covered Dental Services below.
- Orthodontic Treatment that is not medically necessary.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Pulp vitality tests or caries susceptibility tests.
- The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.

Discounts on Non-Orthodontic Dental Services Not Covered By This Plan

A Covered Person under this Policy can receive discounts on certain services not covered by this Policy, as described below, if:

- (a) he or she receives services or supplies from a Dentist that is under contract with Guardian's dental preferred provider organizations (PPOs) network; and
- (b) the service or supply is on the fee schedule the Dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this Policy. The Covered Person must pay the entire discounted fee directly to the Dentist. There is no need to file a claim.

When a person is no longer covered by this Policy, access to the network discount ends.

Discounts on Services Not Covered Due To Contractual Provisions

If a Covered Person receives dental services from a Dentist who is under contract with Guardian's DentalGuard Preferred, such services will be provided at the discounted fee the Dentist agreed to accept as payment in full as a member of our DentalGuard Preferred network, even if such services are not covered by the Policy due to:

- (a) meeting the plan's benefit year payment limit provision;
- (b) frequency limitations; or
- (c) policy exclusions, such as dental implants.

Discounts on Orthodontic Services

If a Covered Person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

- (a) pre-orthodontic treatment visit;
- (b) limited orthodontic treatment;
- (c) interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- (d) comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- (e) periodic comprehensive orthodontic treatment visit (as part of a contract); or
- (f) orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- extractions performed solely to facilitate orthodontic treatment;
- orthognathic surgery and associated incremental charges; and
- replacement of lost or broken retainers.

Required Notice: From time to time Guardian may offer or provide certain persons who apply for coverage with Guardian or become insureds/enrollees with Guardian with discounts on dental services as described above. In addition, Guardian may arrange for third party dental providers, to provide discounted goods and services to those persons who apply for coverage with Guardian or who become insureds/enrollees of Guardian. While Guardian has arranged these goods, services and/or third party provider discounts, the third party service providers are liable to the applicants/insureds/enrollees for the provision of such goods and/or services. Guardian is not responsible for the provision of such goods and/or services nor is it liable for the failure of the provision of the same. Further, Guardian is not liable to the applicants/insureds/enrollees for the negligent provision of such goods and/or services by third party service providers.

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law

Guardian and its subsidiaries comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Guardian and its subsidiaries does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Guardian and its subsidiaries provide free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters; written information in other formats (large print, audio, accessible electronic formats); and provides free language services to people whose primary language is not English, such as: qualified interpreters and Information written in other languages.

If you need these services, call 1-844-561-5600.

If you believe that Guardian or its subsidiaries has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Guardian Civil Rights Coordinator
ATTN: Manager Compliance Metrics, Corporate Compliance
Guardian Life Insurance Company of America
7 Hanover Square - 23F
New York, New York 10004

212-919-3162

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Guardian's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019
1-800-537-7697 (TDD)

Complaint forms are available at:

<http://www.hhs.gov/ocr/office/file/index.html>

IMPORTANT NOTICE REGARDING LANGUAGE ASSISTANCE & DISCRIMINATION

AVISO IMPORTANTE SOBRE LA ASISTENCIA DE IDIOMA Y DISCRIMINACIÓN

English	<p>If you or the person you are helping has questions about your insurance benefits, claims, or coverage, you have the right to get help and information in your language at no cost. To talk to an interpreter: if you have insurance from your employer, call the telephone number on your identification card; for all other members, please call 844-561-5600.</p> <p>The Guardian and its subsidiaries* comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.</p>
Spanish Español	<p>Si usted o la persona que está ayudando tiene preguntas acerca de su seguro, las reclamaciones o cobertura, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete: si tiene seguro de su empleador, llame al número de teléfono que aparece en su tarjeta de identificación; para todos los demás miembros, por favor llame al 844-561-5600.</p> <p>The Guardian y sus subsidiarias * cumplir con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo.</p>
Chinese 中文	<p>如果你或你正在帮助的人拥有约你的保险利益，索赔或覆盖的问题，你有没有成本，以获取帮助和信息在你的语言的权利。要交谈的解释：如果您从您的雇主有保险，打电话给你的身份证上的电话号码;所有其他成员，请致电 844-561-5600。</p> <p>卫报及其子公司*遵守适用的联邦民权法和种族，肤色，国籍，年龄，残疾，或性的基础上不歧视。</p>
Vietnamese Tiếng Việt	<p>Nếu bạn hoặc người bạn đang giúp đỡ có câu hỏi về quyền lợi bảo hiểm, yêu cầu của bạn, hoặc bảo hiểm, bạn có quyền được trợ giúp và thông tin trong ngôn ngữ của bạn miễn phí. Để nói chuyện với một thông dịch viên: nếu bạn có bảo hiểm từ công ty của bạn, hãy gọi số điện thoại trên thẻ nhận dạng của bạn; cho tất cả các thành viên khác, xin vui lòng gọi 844-561-5600.</p> <p>The Guardian và các công ty con của nó * tuân thủ pháp luật quyền dân sự liên bang áp dụng và không phân biệt đối xử trên cơ sở chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, khuyết tật, hoặc quan hệ tình dục.</p>
Korean 한국어	<p>당신이나 당신이 도움이되고 사람이 당신의 보험 혜택, 청구, 또는 범위에 대한 질문이있는 경우, 당신은 무료로 귀하의 언어로 도움과 정보를 얻을 수있는 권리가 있습니다. 통역 얘기하려면, 당신은 당신의 고용주로부터 보험이있는 경우, 귀하의 ID 카드에 전화 번호로 전화; 다른 모든 구성원에 대해, 844-561-5600로 전화 해주십시오.</p> <p>가디언과 그 자회사는 해당 연방 민권법을 준수하고 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 근거하여 차별하지 않습니다*.</p>
Tagalog Tagalog	<p>Kung ikaw o ang taong ikaw ay pagtulong ay may mga katanungan tungkol sa inyong mga benepisyo sa insurance, claims, o coverage, ikaw ay may karapatan upang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang interpreter: kung mayroon kang insurance mula sa iyong tagapag-empleyo, tawagan ang numero ng telepono sa iyong identification card; para sa lahat ng iba pang mga miyembro, mangyaring tumawag sa 844-561-5600.</p> <p>The Guardian at ang mga subsidiaries * sumusunod sa naaangkop na mga Pederal na batas sa mga karapatang sibil at hindi maaaring makita ang kaibhan sa batayan ng lahi, kulay, bansang pinagmulan, edad, kapansanan, o sex.</p>
Russian Русский	<p>Если вы или человек, которому вы помогаете есть вопросы по поводу вашего страховых выплат, претензий, или покрытия, вы имеете право получить помощь и информацию на вашем языке без каких-либо затрат. Для того, чтобы поговорить с переводчиком: если у вас есть страхование от Вашего работодателя, позвоните по номеру телефона на вашей идентификационной карточке; для всех остальных членов, просьба звонить по телефону 844-561-5600.</p> <p>The Guardian и его дочерние компании * соответствии с действующими федеральными законами о гражданских правах и не допускать дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.</p>
Arabic العربية	<p>إذا كنت أنت أو الشخص الذي يساعد فيه 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 5600-561-844.</p> <p>الجاردیان 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..</p>
French Creole-Haitian Creole Kreyòl Ayisyen	<p>Si ou menm oswa moun nan w ap ede gen kesyon sou benefis asirans ou, reklamasyon, oswa pwoteksyon, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou a pa koute. Pou pale ak yon entèprèt: si ou gen asirans nan men anplwayè ou, rele nimewo telefòn sou kat idantifikasyon ou; pou tout lòt manm, tanpri rele 844-561-5600.</p> <p>The Guardian ak filiales li yo * konfòme yo avèk lwa sou dwa sivil Federal aplikab yo, epi pa fè diskriminasyon sou baz ras, koulè, orijin nasyonal, laj, andikap, oswa fè sèks.</p>
Polish Polskie	<p>Jeśli Ty lub osoba, do której pomoc ma pytania dotyczące świadczeń z ubezpieczenia, roszczenia lub pokrycia, masz prawo do uzyskania pomocy i informacji w swoim języku, bez żadnych kosztów. Aby rozmawiać z tłumacza: jeśli masz ubezpieczenie od pracodawcy, należy zadzwonić pod numer telefonu na karcie identyfikacyjnej; dla wszystkich pozostałych członków, zadzwoń 844-561-5600.</p> <p>The Guardian i jej spółek zależnych * przestrzegania obowiązujących przepisów federalnych praw obywatelskich i nie dyskryminacji ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność, czy płeć.</p>

French Français	<p>Si vous ou la personne que vous aidez a des questions sur vos prestations d'assurance, les prétentions ou la couverture, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue, sans frais. Pour parler à un interprète: si vous avez l'assurance de votre employeur, appelez le numéro de téléphone sur votre carte d'identité; pour tous les autres membres, s'il vous plaît appelez 844-561-5600.</p> <p>The Guardian et ses filiales * sont conformes aux lois fédérales relatives aux droits civils applicables et ne fait pas de discrimination sur la base de la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe.</p>
Italian Italiano	<p>Se voi o la persona che state aiutando ha domande circa la vostra prestazioni assicurative, reclami, o la copertura, si ha il diritto di richiedere assistenza e informazioni nella propria lingua, senza alcun costo. Per parlare con un interprete: se avete l'assicurazione dal datore di lavoro, chiamare il numero di telefono sulla carta d'identità; per tutti gli altri membri, si prega di chiamare 844-561-5600.</p> <p>The Guardian e le sue controllate * conformi alle leggi federali vigenti diritti civili e non discrimina sulla base di razza, colore, nazionalità, età, disabilità, o di sesso.</p>
Persian-Farsi فارسی-فارسى	<p>اگر شما یا شخصی که شما در حال کمک به سوالات در مورد مزایای بیمه خود را، ادعا می کند، و یا پوشش، شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشید. برای صحبت با یک مترجم: اگر بیمه از کارفرمای خود، تماس با شماره تلفن بر روی کارت شناسایی خود را. برای همه اعضای دیگر، لطفاً 844-561-5600 تماس بگیرید..</p> <p>گاردین و شرکتهای تابعه آن * * * مطابق با قوانین فدرال حقوق مدنی قابل اجرا می کند و بر اساس نژاد، رنگ پوست، ملیت، سن، معلولیت و یا رابطه جنسی قائل نمی شود.</p>
Armenian Հայերեն	<p>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.</p> <p>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:</p>
German Deutsche	<p>Wenn Sie oder die Person, die Sie helfen, Fragen zu Ihrem Versicherungsleistungen , Ansprüche oder Abdeckung, haben Sie das Recht auf kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um auf einen Dolmetscher sprechen: Wenn Sie eine Versicherung von Ihrem Arbeitgeber haben, rufen Sie die Telefonnummer auf der Ausweis Karte ; für alle anderen Mitglieder, rufen Sie bitte 844-561-5600.</p> <p>The Guardian und ihre Tochtergesellschaften * mit den geltenden Bundes Bürgerrechte Gesetze einhalten und nicht zu diskriminieren auf der Grundlage von Rasse, Hautfarbe , nationaler Herkunft, Alter, Behinderung oder Geschlecht.</p>
Portuguese Português	<p>Se você ou a pessoa que você está ajudando tem dúvidas sobre seus benefícios de seguro, reivindicações, ou cobertura, você tem o direito de obter ajuda e informações na sua língua, sem nenhum custo. Para falar com um intérprete: se você tem seguro de seu empregador, ligue para o número de telefone no seu cartão de identificação; para todos os outros membros, ligue para 844-561-5600.</p> <p>Este aviso tem informações importantes sobre a sua aplicação ou sua cobertura de seguro. Olhe para as datas-chave neste</p> <p>The Guardian e suas subsidiárias * cumprir com as leis federais aplicáveis direitos civis e não discriminar com base em raça, cor, nacionalidade, idade, deficiência ou sexo.</p>

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