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

Individual Dental Family Insurance Policy

POLICYOWNER	Refer to Your ID Card
POLICY NUMBER	Refer to Your ID Card
EFFECTIVE DATE	Refer to Your ID Card
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.
INITIAL PREMIUM:	$

The Guardian Life Insurance Company ("Guardian") certifies that You are being issued this Policy as the Policyholder for the Dental Insurance described in this Policy. This Policy includes the Schedule of Benefits for the plan. **PLEASE READ THIS POLICY CAREFULLY.**

NOTICE: THIS IS A LIMITED BENEFIT POLICY. IT DOES NOT PROVIDE COVERAGE FOR ANY MEDICAL BENEFITS AND SERVICES. THIS IS AN EXCHANGE CERTIFIED STAND ALONE DENTAL POLICY THAT PROVIDES COVERAGE FOR CERTAIN DENTAL BENEFITS AND SERVICES ONLY.

RENEWAL AT THE OPTION OF THE COMPANY
This Policy is conditionally renewable and will continue in effect as long as the Policyowner pays the premiums, as agreed to at the time of application, when they are due or within the grace period in accordance with the terms and conditions of this Policy.

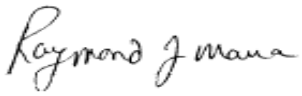
You may renew this Policy for a further term by timely payment of renewal, unless We send You prior notice of Our intention not to renew. If We do refuse to renew We must do so on all Policies of this form issued under the same class in Your state. At least 60 days prior to the premium due date, We will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

We reserve the right to change rates on this Policy issued to persons of the same class in Your state. If We do raise Your premium due to a change in rates, then at least 60 days prior to Your renewal date, We will send written notice to You at Your last known address shown on record.

TEN-DAY RIGHT TO EXAMINE POLICY
You have the right to return this Policy to Guardian within 10 days of receipt, and to have the premium promptly refunded if, after examination, You are not satisfied with this Policy for any reason.

This Policy is governed by the laws of the Commonwealth of Virginia.

IN WITNESS OF WHICH, GUARDIAN has caused this Policy 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

THIS POLICY MAY NOT APPLY WHEN YOU HAVE A CLAIM! PLEASE READ! This policy was issued based on the information entered in your application, a copy of which is attached to the policy. If you know of any misstatement in your application, you should advise the Company immediately regarding the incorrect or omitted information; otherwise, your policy may not be a valid contract.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

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IMPORTANT INFORMATION REGARDING YOUR INSURANCE

In the event You need to contact someone about this insurance for any reason please contact Your agent. If no agent was involved in the sale of this insurance, or if You have additional questions You may contact the insurance company issuing this insurance at the following address and telephone number:

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

If You have been unable to contact or obtain satisfaction from the company or the agent, You may contact:

Virginia State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218]

Telephone Numbers
National Toll-Free Number: (877) 310-6560
Toll-Free Number: (800) 552-7945
Local Number: (804) 371-9691

Written correspondence is preferable so that a record of Your inquiry is maintained. When contacting Your agent, company or the Bureau of Insurance, have Your policy number available. If You have a complaint pertaining to the availability, delivery, or quality of health care services including Adverse Decisions, claims payments, the handling or reimbursement for such service(s), or any other matter, You may contact:

Office of Licensure and Certification
Virginia Department of Health
9960 Maryland Drive - Suite 401
Richmond, VA 23233-1463
Telephone: (804) 367-2106 (Richmond Metro Area)
(800) 955-1819
Fax: (804) 527-4503
E-mail: mchip@vdh.virginia.gov

You have the right to file a complaint.

DENTAL POLICY OF INSURANCE

This Individual Dental Policy, along with the Schedule of Benefits with exclusions and limitations, and application, provide a complete description of how Your Guardian dental plan operates, Your benefits and the plan's restrictions and limitations.

ENTIRE CONTRACT; CHANGES

This contract, including the Policy, Schedule of Benefits with exclusions and limitations, Your application form and the attached papers, constitutes the entire contract of insurance. A copy of your application shall be attached to the Policy when issued. No change in this Policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this contract or to waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date of issue of this Policy, only fraudulent misstatements in the application shall be used to void the coverage or to deny a claim for loss incurred or disability commencing after the expiration of the two-year period. No written statement made by any applicant shall be used in any contest unless a copy of the statement is furnished to the Covered Person or to his or her beneficiary or personal representative.

PROHIBITION OF RESCISSION

Guardian shall not rescind this Policy once You are covered under the Policy, except if You have performed an act or practice that constitutes fraud or make an intentional misrepresentation of a material fact as prohibited by the terms of this Policy. This Policy shall not be cancelled without prior notice to You.

NOTICE REGARDING YOUR RIGHTS AND RESPONSIBILITIES

Rights:

- Guardian will comply with all applicable laws relating to privacy.
- You and Your Dentist are responsible for Your dental treatment. Guardian does not require or prohibit any specified treatment. Only certain specified services are covered for benefits.
- You may request a pre-treatment estimate of benefits for the dental services to be provided. However, actual benefits will be determined after treatment has been performed.
- You may request a written response from Guardian to any written concern or complaint.
- You have the right to receive an explanation of benefits which describes the benefit determinations for Your dental insurance.

Responsibilities:

- You must pay any charges for services performed by the Dentist. If the Dentist agrees to accept part of the payment directly from Guardian, You must pay the remaining part of the Dentist's charge.
- You should follow the treatment plans and health care recommendations agreed upon by You and the Dentist.

ELIGIBILITY AND ENROLLMENT

Who May Enroll

You and any of Your eligible dependents may enroll in this plan. Guardian defines eligible dependents as:

- Your spouse or domestic partner.
- Your children or grandchildren, up to age 26, for whom You provide care, including adopted children, step-children, or other children for whom You are required to provide dental care pursuant to a court or administrative order.
- Your children who are incapable of self-sustaining employment and support due to a intellectual disability or physical handicap.

In the event of the Your death, Your spouse, if covered under the Policy, shall become the Insured.

When Coverage Begins

Coverage will begin at 12:01 A.M. Standard Time on the first day of the month following the date Your premium payment is received by Guardian, so long as the premium is received on or before the twentieth (20th) day of the preceding month. Check with Guardian if You have any questions about when Your coverage begins.

Disenrollment

Enrollment in this dental coverage beyond Your initial twelve (12) month commitment will be automatically continued until You disenroll.

If You disenroll before Your pre-paid rate term expires, You will be charged the monthly rates for any months You were actively enrolled when calculating refund amounts.

Disenrollment may also occur when Your premium payment is not received by the first (1st) of the month following the due date. Please see the "Grace Period" provision below for more information.

Loss of Eligibility

A Covered Person will lose eligibility:

- When Guardian does not receive the required premium payment, subject to the Grace Period, below;
- On the day of the month in which a notice of voluntary termination is received or on such later date as may be specified in the notice;
- On the last day of the month in which he or she no longer meets eligibility requirements.

In the event of contract termination, no further benefits will be provided to You and none of the plan provisions will apply. We will promptly return the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Grace Period

A grace period of thirty-one (31) days will be granted for the payment of each premium falling due after the first premium, during which grace period the Policy shall continue in force (subject to the right of Guardian to cancel in accordance with the Termination of Policy provision.) If no premium is received during the thirty-one (31) days, Your enrollment will be terminated.

Termination of Policy

If the required premium is not paid, Your coverage may be canceled not less than thirty-one (31) days after such premium was due. All periods of insurance will end at 12:01 A.M. Standard Time.

Reinstatement

If the renewal premium is not paid before the Grace Period ends, the policy will lapse. Later acceptance of the premium by Guardian or by an agent authorized to accept payment, without requiring an application for reinstatement, will reinstate the Policy. If the Company or its agent requires an application for reinstatement, the Insured will be given a conditional receipt for the premium. If the application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the forty-fifth (45) day after the date of the conditional receipt unless We had previously written the Insured of its disapproval. The reinstated Policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than ten (10) days after such date. In all other respects the rights of the Insured and Guardian will remain the same, subject to any provisions noted or attached to the reinstated Policy. Any premiums the Company accepts for a reinstatement will be applied to a period for which premiums have not been paid. No premiums will be applied to any period more than sixty (60) days prior to the date of reinstatement.

OVERVIEW OF DENTAL BENEFITS

The Schedule of Benefits contains the benefits and sets forth the Deductibles, coinsurance amounts, and exclusions and limitations. Please review the Schedule of Benefits carefully to understand what benefits are covered under this plan and Your financial responsibility. The Guardian dental plan covers "Dentally Necessary" dental care for Group I (Diagnostic and Preventive), Group II (Basic), and Group III Services (Major). Additionally, Group IV (Orthodontic) Services are covered for Covered Persons under the Age 19.

This Dental Insurance gives Covered Persons access to Dentists who have contracted with Guardian. Contracted Dentists have agreed to limit their charge for a Covered Service to the Maximum Allowed Charge for such service. Under this plan, We pay benefits for Covered Services performed by either Preferred Providers or Non-Preferred Providers. This Guardian plan usually pays a higher level of benefits for Covered Services furnished by a Preferred Provider. Conversely, it usually pays less for Covered Services furnished by a Non-Preferred Provider. A Covered Person will usually be left with less out-of-pocket expense when a Preferred Provider is used.

Deductibles

The Deductible amounts, if any, are shown in the Schedule of Benefits.

Benefit Amounts

We will pay benefits in an amount equal to the Covered Percentage as shown in the Schedule of Benefits for charges incurred for a Covered Service, subject to the conditions set forth in this Policy.

Preferred Provider

If a Covered Service is performed by a Preferred Provider, Guardian will base the benefit on the Covered Percentage of the Maximum Allowed Charge.

If a Preferred Provider performs a Covered Service, You will be responsible for paying:

- The Deductible, if any; and
- Any other part of the Maximum Allowed Charge for which Guardian does not pay benefits.

Non-Preferred Provider

If a Covered Service is performed by a Non-Preferred Provider, Guardian will base the benefit on the charge listed in the fee schedule.

Non-Preferred Providers may charge more than the charge listed in the fee schedule. If a Non-Preferred Provider performs a Covered Service, You will be responsible for paying:

- The Deductible; and
- Any other part of the charge for which Guardian does not pay benefits.

Pre-Treatment Estimates

Pre-Treatment estimate requests are not required but may be submitted to Guardian for more complicated and expensive procedures such as crowns, wisdom teeth extractions, bridges, dentures, or periodontal surgery. When Your Dentist submits a pre-treatment estimate request to Guardian, You will receive an estimate of Your share of the cost and how much Guardian will pay before treatment begins. A pre-treatment estimate is particularly useful in the following cases:

- If You are having extensive work done and the total charges will exceed $300.00;
- To make sure a particular procedure is covered;
- To see if any maximum benefits will be exceeded; or
- If You need to plan Your payment in advance.

By asking Your Dentist for a Pre-treatment estimate from Guardian before You agree to receive any prescribed major treatment, You will have an estimate up front of what the dental plan will pay, and the difference You will need to pay. Your Dentist may also be able to present alternative treatment options that will lower Your share of the bill while still meeting Your dental care needs.

Pre-Authorizations

You must receive pre-authorization approval for all medically necessary orthodontia that is received under this Policy. No claim for medically necessary orthodontia will be paid unless You or Your Dentist obtains pre-authorization approval, in writing, from Guardian prior to receiving any medically necessary orthodontic services.

Customer Service

We provide toll-free access to our Customer Service Associates to assist You with benefit coverage questions, resolving problems, or changing or selecting a Dentist. Customer Service can be reached Monday through Friday at (844) 561-5600 from 6:00 am to 6:00 pm, Pacific Standard Time. Automated service is also provided after hours for eligibility verification.

Selecting Your Dentist

When You enroll in the Guardian plan, You may receive dental care from:

- A Preferred Provider; or
- A Non-Preferred Provider

Please note that You enjoy the greatest benefits, including out-of-pocket savings, when You choose Guardian contracted Dentist. Please refer to the provider directory for a complete listing of Guardian's contracted Dentists. Or You may access our website at dentalexchange.guardianlife.com to view Guardian contracted Dentists. Please check with Your Guardian Dentist to verify that Your plan is accepted.

Changing Your Dentist

You can choose any Guardian contracted provider at any time. If You wish to change Dentists, please review Guardian's provider directory for Dentists in Your area and call to schedule an appointment.

You may also call Customer Service at (844) 561-5600 for assistance in choosing a Dentist.

FILING CLAIMS

Filing a Claim for Dental Insurance Benefits

When You receive services from a Preferred Provider, he or she will file the claim for dental insurance benefits for You. If You need to file a claim Yourself, both the notice of claim and any receipts or other supporting documentation should be sent to Guardian as set forth below. You can request a claim form by calling (844) 561-5600 or from our website at dentalexchange.guardianlife.com.

Notice of Claim

Written notice of claim must be given to Guardian within twenty (20) days after the occurrence or commencement of any loss covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at P O Box 254888, Sacramento, CA 95865 or to any authorized agent with information sufficient to identify the insured, shall be deemed notice to the insurer.

Claim Forms

Upon a notice of claim, Guardian will furnish You with the necessary forms for filing proof of loss. If such forms are not furnished to You within 15 days after receiving such notice, We will accept a written description and adequate proof that is the basis of the claim as proof of loss.

Proof of Loss

Written proof of loss must be furnished to Guardian within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time specified.

Time of Payment of Claims

Benefits will be paid within fifteen (15) days after We receive due written proof in electronic form of a covered loss, or within 30 days after receipt of written proof of a covered loss so long as all information, including supporting documentation, is supplied with the claim.

Payment of Claims

Benefits will be paid to either the Insured or Dentist. Any other benefits unpaid at death may be paid , either to the Insured's beneficiary or the Insured's estate.

The Department of Medical Assistance Services is the payor of last resort

Physical Examinations and Autopsy

The Company at its own expense has the right to have the Insured examined as often as reasonably necessary while a claim is pending. It may also have an autopsy made unless prohibited by law.

Change of Beneficiary

The Insured can change the beneficiary at any time by giving the Company written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

Cancellation by Insured

You may cancel this policy at any time by written notice delivered or mailed to Us effective upon receipt or on such later date as may be specified in the notice. In the event of cancellation, We shall return promptly the unearned portion of any premium paid. The earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Alternative Dental Treatment

If Guardian determines that other procedures, services or courses of treatment could be done to correct a dental condition, coverage will be limited to the least costly procedure that We determine will produce a professionally satisfactory result. In order to make a determination, Guardian may request x-rays and any other appropriate information from the Dentist.

GENERAL PROVISIONS

Assignment

Your rights and benefits under this Policy are not assignable prior to a claim for benefits, except as required by law. We are not responsible for the validity of an assignment. Upon receipt of a Covered Service, You may assign dental insurance benefits to the Dentist providing such service. If You assign payment of dental insurance to the Dentist, We will pay benefits directly to the Dentist. Otherwise, We will pay dental insurance benefits to You.

Recovery of Overpayments

Guardian has the right to recover any amount it determines to be an overpayment for services received. An overpayment occurs if Guardian determines that the total amount paid by Guardian on a claim for dental insurance benefits is more than the total of the benefits due under this Policy.

How We Recover Overpayments

We may recover the overpayments by:

- Stopping or reducing any future benefits payable for dental insurance under this Policy or any other Policy issued to You by Guardian;
- Demanding an immediate refund of the overpayment; and
- Taking legal action.

If the overpayment results from our having made a payment to You or the Dentist, We may recover such overpayment.

Legal Actions

No legal action shall be brought to recover on this Policy within sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No legal action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

COMPLAINT AND APPEAL PROCESS

Definitions

As used in this section:

"*Adverse Determination*" means a determination by the *utilization review entity* that based upon information provided, a request for a benefit upon application of any utilization review technique does not meet the managed care health insurance plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit.

"*Appeal*" means a formal request by a covered person or a provider on behalf of a covered person for reconsideration of a determination such as a utilization review recommendation, a benefit payment, an administrative action, or a quality-of-care or service issue.

"*Appellant*" means: (i) the covered person; (ii) the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor; (iii) the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person if the covered person is not a minor but is incompetent or incapacitated; or (iv) the covered person's treating health care provider acting with the consent of the covered person, the covered person's parent, guardian, legal custodian, or other individual authorized by law to act on behalf of the covered person, if the covered person is a minor, or the covered person's spouse, parent, committee, legal guardian, or other individual authorized by law to act on behalf of the covered person, if the covered person is not a minor but is incompetent or incapacitated.

"*Complaint*" means a written communication primarily expressing a grievance. A complaint may pertain to the availability, delivery, or quality of health care services including *adverse determinations*, claims payments, the handling or reimbursement for such service(s), or any other matter pertaining to the covered person's contractual relationship with the *Managed Care Health Insurance Plan* (*MCHIP*).

"*Concurrent review*" means *utilization review* conducted during a patient's stay or course of treatment in a facility, the office of a health care professional, or other inpatient or outpatient health care setting.

"*Final adverse determination*" means an *adverse determination* involving a covered benefit that has been upheld by a managed care health insurance plan, or it's designee *utilization review entity*, at the completion of the managed care health insurance plan's internal appeal process.

"*Independent review organization*" means an organization selected by the Bureau of Insurance that conducts external reviews of *adverse determinations* and *final adverse determinations*.

"*Managed care health insurance plan*" or "*MCHIP*" means an arrangement for the delivery of health care in which Guardian undertakes to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis which: i) contains one or more incentive arrangements, including any credentialing requirements intended to influence the cost or level of health care services between the health carrier and one or more providers with respect to the delivery of health care services; and ii) requires or creates benefit payment differential incentives for covered persons to use providers that are directly or indirectly managed, owned, under contract with or employed by the health carrier. For the purposes of this definition, the prohibition of balance billing by a provider shall not be deemed a benefit payment differential incentive for covered persons to use providers who are directly or indirectly managed, owned, under contract with or employed by the health carrier. A single managed care health insurance plan may encompass multiple types of benefit payment differentials; however, a single managed care health insurance plan shall encompass only one provider network or set of provider networks.

"*Medically necessary*" means appropriate and necessary health care services which are rendered for any condition which, according to generally accepted principles of good medical practice, requires the diagnosis or direct care and treatment of an illness, injury, or pregnancy-related condition, and are not provided only as a convenience.

"*Peer of the treating health care provider*" means a physician or other health care professional who holds a nonrestricted license in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

"*Physician advisor*" means a physician licensed to practice medicine in the Commonwealth of Virginia or under a comparable licensing law of a state of the United States who provides medical advice or information to a private review agent or a *utilization review entity* in connection with its *utilization review* activities.

"*Prospective review*" means *utilization review* conducted prior to an admission or a course of treatment.

'*Retrospective review*" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjustment for payment.

"*Timely*" means the provision of services so as not to impair or jeopardize the integrity of the covered person's diagnosis or outcomes of illness.

"*Treating health care provider*" or "*Provider*" means:

a) a licensed health care provider who renders or proposes to render health care services to a covered person; and

b) for purposes of this provision, is acting on behalf of the covered person.

"*Urgent Care Appeal*" means an *appeal* for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations (i) could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or (ii) in the opinion of the treating health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the *appeal*. an *urgent care appeal* shall not be available for any post-service claim or retrospective adverse determination.

"*Utilization Review*" means a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a covered person for the purpose of determining whether such services should be covered. Utilization review includes, but is not limited to, preadmission, concurrent and retrospective *medical necessity* determination, and review related to the appropriateness of the site at which services were or are to be delivered. Utilization review also includes determinations of medical necessity based upon contractual limitations regarding "experimental" or "investigational" procedures, by whatever terms designated in the evidence of coverage. Utilization review does not include any: (i) denial of benefits for a procedure which is explicitly excluded pursuant to the terms of the contract or evidence of coverage; (ii) review of issues concerning contractual restrictions on facilities to be used for the provision of services; or (iii) determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any other classes of insurance.

"*Utilization review entity*" or "*entity*" means an insurer or managed care health insurance plan licensee that performs utilization review or upon whose behalf utilization review is performed with regard to the health care or proposed health care that is the subject of the final adverse determination.

Internal Appeal Procedures

Complaint Process: If a covered person has concerns regarding a quality of care issue, he or she may file a *complaint* as follows:

In Writing: Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
3600 W. Broad Street Suite 216
Richmond, VA 23230
Telephone: 804-367-2104 (Richmond Metro Area)
800-955-1819

Fax: 804-367-2149
E-mail: mchip@vdh.state.va.us

If a covered person or his or her *treating health care provider* does not agree with a *utilization review* determination, his or her *provider* may file, within 180 days of receipt of the *determination*, a *complaint* to request reconsideration of the *adverse determination.*

A *complaint* for reconsideration of a *utilization review* determination made by Guardian should be made to:

Guardian MRO Quality Assurance Group Quality Assurance-WRO Professional Relations VP
PO Box 2457
Spokane, WA 99210-2457**.**

The *provider's* written *complaint* requesting reconsideration should provide the *utilization review entity* with any added information which: (a) relates to the case; and (b) may impact on the first determination. A determination on reconsideration will be made by a *physician advisor*, *peer of the treating health care provider*, or a panel of other appropriate health care providers with at least one *physician advisor* or *peer of the treating health care provider* on the panel.

Resolution of the *complaint*, and written notification of such determination will be provided to the covered person and the *treating health care provider* no later than ten (10) working days after receipt of the *complaint*.

The written notification of such determination will include the criteria used and the clinical reason for the *adverse determination*, and, if any, the alternate length of treatment of the alternate treatment setting(s) that the *utilization review entity* deems to be appropriate.

If the reconsideration results in a *final adverse determination*, the covered person, his or her *provider*, or a representative of the covered person may *appeal* the *final adverse determination*.

Appeals of Adverse Determinations: Except as explained below for an urgent care appeal, a covered person, his or her *treating health care provider*, or a representative of the covered person may make a written request for an *appeal* of an *adverse determination* or a *final adverse determination* made by the *utilization review entity*.

An *appeal* for reconsideration of a determination made by Guardian should be made to:

Guardian MRO Quality Assurance Group Quality Assurance-WRO Professional Relations VP
PO Box 2457
Spokane, WA 99210-2457.

The request for *appeal* of a determination should provide the *utilization review entity* with any additional evidence for consideration (e.g., pertinent medical records of the covered person's *provider*, the pertinent records of any facility in which health care is provided to the covered person, etc.).

Any information provided to the *utilization review entity* to support an *appeal* will be reviewed by a *physician advisor* or a *peer of the treating health care provider*. With the exception of expedited *appeals*, a *physician advisor* must be:

a) a *peer of the treating health care provider* who proposes the care under review or who was primarily responsible for the care under review;

b) board certified; and

c) specialized in a discipline pertinent to the issue under review.

A *physician advisor* or *peer of the treating health care provider* who renders a decision on *appeal* must:

a) not have participated in the *adverse decision* or any prior reconsideration thereof;

b) not be employed by or be a director of the *utilization review entity*; and

c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a *peer of the treating health care provider*.

In the *appeals* process, consideration will be given to the availability or non-availability of alternative health care services proposed by the *utilization review entity*.

Except for *urgent care appeals*, written notification of the results of the *appeal* process will be provided to the covered person, his or her *treating health care provider*, or the representative of the covered person who filed the *appeal.* Notification for *prospective reviews* will be provided no later than thirty (30) working days after receiving all required documentation. Notification for *retrospective reviews* will be no later than sixty (60) working days after receiving all required documentation. Notification for *concurrent care reviews* will be provided sufficiently in advance of a reduction or termination of a benefit after receipt of the claim to allow the *appellant* to *appeal* and obtain a determination on review before the benefit is reduced or terminated but in no case will this be less than thirty (30) working days after receiving all required documentation. The notification of all decisions will state the criteria used and the clinical reason for the decision.

Urgent Care Appeals of Adverse Determinations: When the *treating health care provider* believes that an *adverse determination* or adverse reconsideration warrants an immediate *appeal*, the *treating health care provider* shall have the opportunity to *appeal* on an urgent care basis.

An *urgent care appeal* may be requested only when the regular reconsideration and *appeals* process would delay the rendering of health care in a manner that would be detrimental to the health of the covered person. Both the *utilization review entity* and the *treating health care provider* must attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the *urgent care appeal* in a satisfactory manner.

A written or oral *appeal* for *urgent care* reconsideration of an *adverse determination* or a *final adverse determination* made by Guardian should be made to:

Guardian Quality Assurance-WRO
PO Box 2457
Spokane, WA 99210-2457
Phone: 1-800-541-7846
Fax: 1-509-468-6399

If additional information is needed to make a determination, the *appellant* will be notified of the specified information needed as soon as possible but not later than twenty-four (24) hours after receipt of the request for appeal. Such notice will be provided orally or, if requested by the *appellant*, it shall be provided in writing and shall state what specified information is needed. The *appellant* must provide the requested information within forty-eight (48) hours.

Any decision of an *urgent care appeal* must be made by a *physician advisor*, *peer of the treating health care provider*, or a panel of other appropriate health care providers with at least one *physician advisor* on the panel. A decision on a prospective *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination. A decision on an concurrent *urgent care appeal* will be made by the *utilization review entity* no later than seventy-two (72) hours after receipt by the *utilization review entity* of all information necessary to make such a determination, but the request to continue treatment must be received at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

An *urgent care appeal* determination may be further appealed through the *utilization review entity's* standard *appeal* process If:

a) all material information and documentation was not reasonably available to the provider and to the *utilization review entity* at the time of the *expedited review appeal*;

b) the *physician advisor* reviewing the case under an *urgent care review appeal*: i) was not a *peer of the treating health care provider*; and ii) was not board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

If the review of an *urgent care appeal* by a *utilization review entity* results in a *final adverse determination*, the *utilization review entity* will immediately notify the person who requested the *urgent care appeal* of the *final adverse determination*.

Consumer Assistance

If you have any questions regarding an appeal or grievance concerning the health care services that you have been provided that have not been satisfactorily addressed by your plan, you may contact the Office of the Managed Care Ombudsman for assistance.

The Office of the Managed Care Ombudsman is charged with protecting the interests of *covered persons* under *MCHIP's* in the Commonwealth of Virginia. For purposes of this plan, the Office of The Managed Care Ombudsman must:

1) assist *covered persons* in understanding their rights and the processes available to them according to their *managed care health insurance plan*;

2) answer inquiries from *covered persons*, their *treating health care providers*, and any representative of the *covered person* received via telephone, mail, electronic mail or in person;

3) provide to *covered persons*, their *treating health care providers*, and any representative of the *covered person* information concerning *managed health care insurance plans* and other *utilization review entities* upon request;

4) upon request, assist *covered persons* in using the procedures and processes available to them from their *managed care health insurance plan*, including all *utilization review appeals*. Such assistance may require the review of insurance and health care records of a *covered person*, which shall be done only with the express written consent of the *covered person*. The confidentiality of all such information shall be maintained in accordance with the laws of the Commonwealth of Virginia.

5) ensure that *covered persons* have access to the services provided through the Office and that the *covered persons* receive timely responses from the representatives of the Office to the inquiries.

The address, telephone number, or E-mail address shown below should be used:

a) in order to obtain assistance with any questions regarding an *appeal* or *complaint* concerning the health care services provided which have not been satisfactorily addressed by the *utilization review entity*; or

b) in order to obtain assistance with the filing of an *appeal* regarding a *final adverse determination* with the Bureau of Insurance; or

c) in order to obtain the *appeal* and authorization for release of medical information forms and any written
procedures necessary to register an *appeal* with the Bureau of Insurance regarding a *final adverse determination*.

Address: Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218

Telephone: 1-877-310-6560 toll-free
1-804-371-9032 in the Richmond Metropolitan Area

Ombudsman E-mail: ombudsman@scc.virginia.gov

Bureau of Insurance Website: www.scc.virginia.gov

DEFINITIONS

These definitions apply when the following terms are used, unless otherwise defined where they are used. Not all defined terms are used in their usual meaning and some have meanings that limit their application; therefore, please refer to this Definitions section for a helpful understanding of the defined terms that are capitalized.

Covered Percentage means:

- For a Covered Service performed by a Preferred Provider, the percentage of the Maximum Allowed Charge that We will pay for such services after any required Deductible is satisfied; and
- For a Covered Service performed by a Non-Preferred Provider, the percentage of the charge listed in the fee schedule that Guardian will pay for such services after any required Deductible is satisfied.

All Covered Percentages are included in the Schedule of Benefits for each Covered Service.

Covered Person means a person for whom Dental Insurance coverage has been purchased so long as it is in effect under this Policy.

Covered Service means a dental service used to treat a Covered Person's dental condition which is:

- prescribed or performed by a Dentist while the dental insurance provided by this Policy is in effect;
- Dentally Necessary to treat the condition; and
- Described in the Schedule of Benefits as a Covered Service.

Deductible means the amount You must pay before Guardian will pay for Covered Services.

Dentally Necessary means the services are required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's dental condition due to dental disease, in order to attain or maintain the individual's achievable dental health, provided that such services are:

- Consistent with generally accepted standards of dental practice that are defined standards and are based on credible scientific evidence published in peer- reviewed dental literature that is generally recognized by the relevant dental community, recommendations of a dental-specialty academy, the views of Dentists practicing in the relevant clinical areas, and any other relevant factors;
- Clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's dental condition;
- Not primarily for the convenience of the patient or Dentist;
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's dental condition; and
- Based on an assessment of the individual and his or her dental condition.

We will not pay dental insurance benefits for charges incurred for:

- Services which are not Dentally Necessary Services, those which do not meet generally accepted standards of care for treating the particular dental condition, or which We deem experimental in nature.

- Services for which You would not be required to pay in the absence of dental insurance.
- Services which are primarily cosmetic (including cosmetic orthodontia.)

Dentist means:

- A person licensed to practice dentistry in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as Dentist's services for purposes of this Policy. Each such person must be licensed where the services are performed and must act within the scope of that license. The person must also be certified and/or registered if required.

Preferred Provider means a Dentist or dental care facility that is under contract with Guardian and has a contractual agreement with Guardian to accept the Maximum Allowed Charge as payment in full for a dental service.

Maximum Allowed Charge means the lesser of:

- The amount charged by the Dentist; or
- The charge listed in the fee schedule the Preferred Provider has agreed to accept as payment in full.

Non-Preferred Provider means a Dentist or dental care facility that is not under contract with Guardian.

We means The Guardian Life Insurance Company of America (“Guardian”).

You or Your means the insured.

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

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	Refer to Your ID Card
POLICY ANNIVERSARIES:	The Anniversary of the Effective Date, Each Year.

Cash Deductible Information

Deductible per Insured per Benefit Year

Preferred Provider Benefit Year Cash Deductible:
Group I, Group II and Group III Services.....$75.00

Non-Preferred Provider Benefit Year Cash 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	50%
Group III Services	50%
Group IV (Orthodontic) Services	0%

Non-Preferred Provider Payment Rate for:

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

Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximum

Annual Maximum per Covered Person	$1,000.00

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 under the age of 19 who are eligible for the Pediatric Dental Services explained below.

Pediatric Dental Services Cash Deductible Information

Deductible per Insured Child per Benefit Year

Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services	$75.00
Group IV Services	None

Non-Preferred Provider Benefit Year Cash Deductible:

Group I, Group II and Group III Services	$150.00
Group IV 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 100%
Group II Services 50%
Group III Services 50%
Group IV (Orthodontic) Services 0%

Pediatric Dental Services Maximums and Waiting Periods

Preferred Provider and Non-Preferred Provider Annual Maximums:
Group I, Group II, Group III and Group IV Services ..... 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 Services ..... None

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) information about current Preferred Providers.

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.

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.

How to Reach Us

Claim Dept. P O Box 254888, Sacramento, CA 95865	Member Services Line (844) 561-5600	On the Web dentalexchange.guardianlife.com

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 (Cleaning) and Fluorides

Prophylaxis - Cleaning (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.

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.

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.

Surgical Extractions

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

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

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

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

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Biopsy and examination of tooth related oral tissue.

Brush biopsy

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision of tooth related tumors, cysts and neoplasms.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

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 Policy:** 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 Policy. 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 Policy.

Exclusions

We will not pay for:

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Treatment needed due to: (1) an on-the-job or job-related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this Plan.
- Any service furnished solely for cosmetic reasons, unless this Plan provides benefits for 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 Pediatric Dental Services required by your State.

Group I Services (Diagnostic & Preventive)

Prophylaxis (Cleaning) and Fluorides

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

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

Space Maintainers

Space Maintainers: Limited to initial Appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per 12 consecutive month period.

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

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

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

Radiographs

Allowance includes evaluation and diagnosis.

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

- Full mouth series, of at least 14 images including bitewings.

- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

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

Intraoral periapical or occlusal images- single images.

Dental Sealants

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

Group II Services (Basic)

Restorative Services

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

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

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

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

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

Diagnostic Services

Allowance includes examination and diagnosis.

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

Diagnostic casts

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

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

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. Limited to once, per tooth, in any 60 consecutive month period. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only. Also see Exclusions sections for replacement and limitations. Single Crowns:

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

Inlays.

Onlays, including inlay.

Labial veneers.

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

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

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

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

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

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

Other implant services:

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

Prosthodontic Services

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

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

Bridge abutments:

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

Bridge Pontics:

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

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

Complete or immediate dentures, upper or lower.

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

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

Simple stress breakers, per unit.

Crown and Prosthodontic Restorative Services

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

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

- Inlay or onlay.
- Crown.
- Bridge.

Adding teeth to partial dentures to replace extracted natural teeth.

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

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

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

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

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

Tissue conditioning: Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the Dentist who furnished the

denture. Limited to a maximum of one treatment, per arch, in any 12 consecutive month period.

Other Services

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

Detailed and extensive oral evaluations – problem focused, by report

Endodontic Services

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

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

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

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

Pulpal debridement.

Pulpal therapy: Limited to primary teeth only.

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

Periodontal Services

Periodontal maintenance: Limited to a total of four periodontal maintenance or prophylaxis (cleaning) 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 12 consecutive month period.

Provisional splinting – intracoronal, extracoronal: Limited to once per arch, per lifetime.

Periodontal Surgery

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

The treatment listed below is limited to, once per tooth in any 12 consecutive month period.

- Crown lengthening, hard tissue.

The treatment listed below is limited to once in any 24 consecutive month period.

- Gingivectomy or gingivoplasty, per quadrant (four or more teeth)
- Gingivectomy or gingivoplasty, per tooth (one to three teeth)

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

- 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.

Surgical Extractions

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

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

Surgical removal of residual tooth roots.

Surgical removal of impacted teeth.

Other Oral Surgical Procedures

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

Alveoloplasty, per quadrant.

Removal of exostosis, per site.

Incision and drainage of abscess.

Frenulectomy, frenectomy, frenotomy.

Surgical exposure of impacted or unerupted tooth to aid eruption.

Excision or destruction of tooth related lesion(s).

Excision of hyperplastic tissue.

Excision of pericoronal gingiva, per tooth.

Oroantral fistula closure.

Vestibuloplasty.

Tooth reimplantation.

Group IV Services (Orthodontics/Orthodontia)

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

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.

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

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.