The Guardian Life Insurance Company of America

A Mutual Company – Incorporated 1860 by the State of New York
New York, New York 10001

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:	See Invoice

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.

GUARANTEED RENEWABLE
This Policy is guaranteed renewable and will continue in effect as long as the Policyowner pays the premiums 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 until age 65 or until eligibility for Medicare. During this period We have no right to make unilaterally any change in any provision of the Policy while in force, except We reserve the right to change rates on this Policy when rates are also changed for all Policyowners issued this plan 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.

Eleana Cheng, CEO Guardian Direct

Harris Oliner, Senior Vice President and Corporate Secretary

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."

THIS POLICY IS CONSIDERED AN ACA COMPLIANT DENTAL PLAN and this Policy is subject to regulation in the Commonwealth by both the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and the Virginia Department of Health pursuant to Title 32.1.

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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
New York, New York 10001
(800) 404-5771
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. Guardian issues this policy in consideration of your completed application and the first premium payment.

ENTIRE CONTRACT; CHANGES

This policy is a legal contract between You and Us. 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.

PREEXISTING CONDITIONS

No claim for loss incurred or disability (as defined in the policy) that starts after one year from the date of issue of this policy will be reduced or denied because a sickness or physical condition, not excluded by name or specific description before the date of loss, had existed before the effective date of coverage.

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

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.

Minimum Enrollment Period

For plans purchased through the Exchange: In addition to the annual enrollment set by the Exchange, there are certain events that qualify as a special enrollment period. Special enrollment period means a period of time that is no less than 60 days following the date of a triggering event during which: 1. individuals are permitted to enroll in a standard health benefits plan or standard health benefits plan with rider; and 2. individuals who already have coverage are allowed to replace current coverage with a different standard health benefits plan or standard health benefits plan with rider.

Triggering event means an event that results in an individual becoming eligible for a special enrollment period. Triggering events are: a) The date a Covered Person loses eligibility for minimum essential coverage, or a covered dependent loses eligibility for minimum essential coverage, including a loss of coverage resulting from the decertification of a qualified health plan by the marketplace. b) The date a dependent child's coverage ends as a result of attaining age 26 whether or not the dependent is eligible for continuing coverage in accordance with federal or state laws. c) The date a dependent child's coverage under a parent's group plan ends as a result of attaining age 31. d) The effective date of a marketplace redetermination of a Covered Person's subsidy, including a determination that a Covered Person is newly eligible or no longer eligible for a subsidy. e) The date a Covered Person acquires a dependent due to marriage, birth, adoption, placement for adoption, or placement in foster care. f) The date a Covered Person who is covered under an individual health benefits plan or group health benefits plan moves out of that plan's service area. g) The date of a marketplace finding that it erroneously permitted or denied a Covered Person enrollment in a qualified health plan. h) The date the Covered Person demonstrates to the marketplace that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee.

Exception: A loss of coverage resulting from nonpayment of premium, fraud or misrepresentation of material fact shall not be a triggering event.

Loss of Eligibility

A Covered Person will lose eligibility:

- When Guardian does not receive the required premium payment, subject to the Grace Period, below; or
- 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.

If We accept premium on a date after which the coverage provided by the Policy would not be effective, the coverage provided by the Policy shall continue in force until the end of the period for which the premium has been accepted.

In the event of contract termination, no further benefits will be provided to You and none of the plan provisions will apply. 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. If no premium is received during the thirty-one (31) days, Your enrollment will be terminated.

If You are receiving a premium tax credit for this coverage, You have a grace period of 90 days from the date Your premium is due to pay Your premium. During the first 31 days of the grace period, this Policy will continue in force. If premiums are not received by the 31st day of the grace period, claims will be placed on hold until the 90th day of the grace period. If premiums are not received by the 90th day of the grace period, Your policy will be terminated as of the 31st day of the grace period.

Unpaid Premium

When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

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 and for pediatric dental services, coverage begins on the date of reinstatement. 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 9:00 am to 9:00 pm, Eastern 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 in the Commonwealth of Virginia or in any other state, 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 a 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.guardiandirect.com to view Guardian contracted Dentists. Please check with Your Guardian Dentist to verify that Your plan is accepted. You may also request a printed copy of our provider directory by contacting us as described under Customer Service above.

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.guardiandirect.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 981587, El Paso, TX 79998-1587 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, You shall meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

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 for any loss covered by this policy will be paid as soon as We receive proper written proof.

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 Life Insurance Company of America

Attn: Complaints & Grievances Department
PO Box 2474
Spokane, WA 99210-2474**.**

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 Life Insurance Company of America
PO Box 981587
El Paso, TX 79998-1587

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 Life Insurance Company of America
PO Box 2474
Spokane, WA 99210-2474
Phone: 1-866-569-9900
Fax: 1-818-569-5853

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.

Appliance means any dental device other than a Dental Prosthesis.

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 Non-Pediatric Dental Services and Pediatric Dental Services.

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

Dental Prosthesis means a restoration or device which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of: (1) bridge retainer crowns, inlays, and onlays; (2) bridge pontics; (3) complete and immediate dentures; (4) partial dentures; and (5)(a) crowns; (b) inlays (c) onlays (d) veneers; (e) implants; and (f) posts and cores.

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, subject to the complaint and appeal process in this policy.
- 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.

Payment Rate 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.

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.