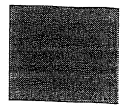
YOUR GROUP INSURANCE PLAN

THE TRUSTEES OF THE AFFILIATED PHYSICIANS &
EMPLOYERS MASTER TRUST
CLASS 0001
DENTAL - ASO VALUE PLAN



EVIDENCE OF COVERAGE

This evidence of coverage verifies that the employee named below is covered by the Plan Sponsor for the benefits described in this booklet, provided the eligibility and enrollment requirements are met.

Plan No.	Evidence No.	Effective Date
Issued To		

This EVIDENCE OF COVERAGE replaces any EVIDENCE OF COVERAGE previously issued under the above Plan which describes similar or identical benefits provided by the Plan Sponsor.

B110.0051-R

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IMPORTANT NOTICE

These benefits are directly funded through and provided by your employer, and are not insured by Guardian. Guardian supplies administrative services, such as: claims services and preparation of employee benefit booklets.

Your employer, has the sole responsibility and liability for payment of these benefits.

As used in this booklet, the terms:

- "certificate" refers to this booklet describing the benefits directly funded through and provided by your employer;
- "insurance" and "insured" refers to the benefits directly funded through and provided by your employer;
- "plan", "we", "us" and "our" refer to the benefits that are directly funded through and provided by your employer, and are not insured by Guardian;
- "premium," "premiums," and "premium charge" refer to payments required from you for coverage under this plan; and
- "proof of insurability" refers to any evidence of your good health which may be required under this plan.

All terms and provisions, maximums or limitations set forth in this booklet will be applicable to these benefits provided by your employer.

B115.0126-R

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to the employer's plan. You must contact your employer to find out if: (a) the employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to you.

B235.0109-R

Federal Continuation Rights

Important Notice

This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverage for loss of income due to disability. This coverage can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active, covered employee; or (c) the dependent child of an active covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

If Your Group Health Benefits End

If you are a qualified continuee and your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

The continuation: (a) may cover you or any other qualified continuee; and (b) is subject to "When Continuation Ends".

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

B235.0148-R

If You Die While Covered

If you die while covered, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility

If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations

If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; (b) the loss of dependent eligibility, as defined in this plan, of a covered dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

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

Notice of a disability determination must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

B235.0181-R

Your Employer's Responsibilities

Your employer must notify the qualified continuee, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the payments he or she must make to continue such benefits; and (c) the times and manner in which such payments must be made.

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give your employer written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from your employer as described above; or (b) the date coverage would otherwise end. And the qualified continuee must make his or her first payment in a timely manner.

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

The payment will be the total cost of coverage for the group health benefits had the qualified continuee stayed covered under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total cost of coverage may also be required by your employer.

If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to make any required payments in a timely manner, he or she waives his or her continuation rights.

Grace in Payment

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

When Continuation Ends

A qualified continuee's continued group health benefits end on the first of the following:

(1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) the date the employer ceases to provide any group health plan to any employee;

(5) the end of the period for which the last payment is made;

(6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(7) the date, after the date of election, he or she becomes entitled to Medicare.

B235.0190-R

Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under this *plan* as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If your group health benefits under this *plan* would otherwise end because you enter into active military service, this *plan* will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this *plan.*

Coverage under this plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments.

B235.0194-R

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002-R

Employee Coverage

Eligible Employees To be eligible for *employee* coverage you must be an active *full-time employee.* And you must belong to a class of *employees* covered by this *plan.*

Other Conditions If you must pay all or part of the cost of *employee* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan,* and you now elect to enroll in the dental coverage under this *plan,* the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's *plan;* (c) divorce; (d) death of your spouse; or (e) termination of the other *plan.*

But you must enroll in the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

B489.0365-R

Dental Plan Election Procedures Since Managed DentalGuard is offered to you as an alternative to this dental coverage, you may change your election, and enroll in Managed DentalGuard as follows.

If you drop your coverage under this *plan,* at any time other than during an open enrollment period, you may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If you remain covered under this plan, you may change your election, and enroll in Managed DentalGuard during an open enrollment period. Your coverage under this *plan* ends on the date coverage under Managed DentalGuard begins.

An "open enrollment period" is a 30 day period occurring once every 12 months after this plan's effective date, or at time intervals agreed upon by the *employer* and us.

If you change your election, your covered dependents will automatically be switched to Managed DentalGuard at the same time as you.

B489.0371-R

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active *full-time* work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

B489.0356-R

When Your Coverage Ends

Your coverage ends on the last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

It also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan,* or when this *plan* ends for all *employees.* And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

B489.0374-R

Your Right To Continue Group Coverage During A Family Leave Of Absence

Important Notice

This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

If Your Group Coverage Would End

Group coverage may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty(or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an *employee* who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the *employee* under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other *employee;* or (b) any later 12 month period in the case of an *employee* who cares for a covered servicemember.
- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

Definitions

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

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

B489.0359-R

B200.0271-R

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 26; and (c) your unmarried dependent children from age 26 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan.* You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary.*

Your "legal spouse" includes a partner to a civil union when that union is in accordance with New Jersey law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

B489.0311-R

Adopted Children And Step-Children

Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And we exclude any dependent who is on active duty in any armed force.

B264.0007-R

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the *plan,* such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

B449.0042-R

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

B200.0749-R

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan,* the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

If you do this on or before your *eligibility date,* the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for employee coverage.

If you do this within the *enrollment period,* the coverage is scheduled to start on the date you become insured for employee coverage.

If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the *newly acquired dependent,* when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

B489.0254-R

Exception If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

B200.0692-R

Newborn Children We cover your newborn child for dependent benefits, from the moment of his or her birth if: (a) you are already covered for dependent child coverage when the child is born; or (b) you enroll the child for dependent coverage within 31 days of the child's birth and agrees to make any required premium payments within 31 days of the date the child is born. If you fail to do this, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

B489.0008-R

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain *eligible dependents;* and (c) in the case of a spouse, the spouse does not remarry. And we'll also automatically cover a newborn child born to your spouse within six months of your death. But any such newborn child's coverage will end six months from the date you died. There is no cost for this coverage. If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan,* if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of *employees* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *employees* or for an *employee's* class.

If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child on the last day of the month in which the child attains this coverage's age limit, when he or she marries, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

B489.0278-R

CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner will be eligible for dental coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

This rider is part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

B210.0038-R

DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Expense Insurance *plan* features which people most often want to know about. But it's not a complete description of your Dental Expense Insurance *plan.* Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- **PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

- **Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

  For Group I Services . . . . . None
  For Group II and III Services $50.00
  for each covered person

B497.0070-R

- **Payment Rates for Services Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 50%
  For Group III Services 50%
  For Group IV Services 50%

- **Payment Rates for Services Not Furnished by a Preferred Provider:**

  For Group I Services 100%
  For Group II Services 40%
  For Group III Services 30%
  For Group IV Services 50%

B497.0089-R

- **Benefit Year Payment Limit for Non-Orthodontic Services**

  For Group I, II and III Services . . . . . Up to $1,000.00

- **Lifetime Payment Limit for Orthodontic Treatment**

  For Group IV Services . . . . . Up to $1,000.00

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

B497.1432-R

DENTAL EXPENSE INSURANCE

This insurance will pay many of a *covered person's* dental expenses. *We* pay benefits for covered charges incurred by a *covered person.* What *we* pay and terms for payment are explained below.

B498.0007-R

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO),* 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 anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider.* Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider.*

When an *employee* enrolls in this *plan,* he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers.*

A *covered person* must present his or her ID card when he or she uses a *preferred provider.* Most *preferred providers* prepare necessary claim forms for the *covered person,* and submit the forms to *us.* We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider.*

What *we* pay is based on all of the terms of this *plan.* Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits.*

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan.*

B498.0151-R

Covered Charges

Covered charges for group dental plans in New Jersey, regardless of whether a *covered person* uses the services of a preferred provider or a non-preferred provider, are the charges determined in accordance with the Schedule of Dental Fee Amounts. The Schedule illustrates the fee amounts used to determine covered charges for the specified ADA Code. The Schedule does not guarantee that *we* will pay the amounts listed. What *we* pay is subject to all the terms of this *plan,* including deductibles, payment rates, payment limits, *plan* frequencies, exclusions and other limitations.

A preferred provider agrees to accept the charges shown in the Schedule as payment in full for the dental services listed in this *plan's* List of Covered Dental Services. A non-preferred provider may bill the *covered person* for the difference between what the provider charges for a service and what this *plan* pays for such service.

To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

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

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

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

Schedule of Dental Fee Amounts
For Informational Purposes Only

The following Schedule, which is provided for informational purposes only, illustrates the fee amounts used to determine covered charges for the specified ADA Code from the Current Dental Terminology (c) American Dental Association for group dental plans in New Jersey. Covered charges are based on the Schedule regardless of whether a covered person uses the services of a preferred provider or a non-preferred provider.

This Schedule does not guarantee that we will pay the amounts listed. What we pay is subject to all the terms of this *plan,* including deductibles, payment rates, payment limits, *plan* frequencies, exclusions and other limitations.

Your *plan* may not include all of the listed codes as covered services. See the List of Covered Dental Services.

The ADA Codes, Descriptions and Fee Amounts are subject to change.

		Fee Amounts	
ADA Codes	**Description**	**General Dentist**	**Specialist**
D0120	Periodic Oral Evaluation - Established Patient	$23	$30
D0140	Limited Oral Evaluation - Problem Focused	$35	$48
D0145	Oral Evaluation For A Patient Under Three Years Of Age And Counseling With Primary Caregiver	$35	$49
D0150	Comprehensive Oral Evaluation - New Or Established Patient	$35	$49
D0170	Re-Evaluation-Limited - Problem Focused (Established Patient; Not Post Operative Visit)	$32	$43
D0180	Comprehensive Periodontal Evaluation - New Or Established Patient	$35	$49
D0210	Intraoral - Complete Series (Including Bitewings)	$68	$91
D0220	Intraoral - Periapical First Film	$13	$19
D0230	Intraoral - Periapical Each Additional Film	$9	$12
D0240	Intraoral - Occlusal Film	$19	$25
D0250	Extraoral - First Film	$18	$27
D0260	Extraoral - Each Additional Film	$9	$13
D0270	Bitewing - Single Film	$17	$21
D0272	Bitewing - Two Films	$21	$27
D0273	Bitewing - Three Films	$23	$30
D0274	Bitewing - Four Films	$31	$42
D0277	Vertical Bitewings-7 To 8 Films	$42	$57

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D0310	Sialography	$204	$273
D0330	Panoramic Film	$58	$78
D0431	Adjunctive Pre-Diagnostic Test That Aids In Detection Of Mucosal Abnormalities Including Premalignant And Malignant Lesions, Not To Include Cytology Or Biopsy Procedures	$37	$47
D0470	Diagnostic Casts	$51	$68
D1110	Prophylaxis - Adult	$48	$61
D1120	Prophylaxis - Child	$34	$45
D1203	Topical Application Of Fluoride (Prophylaxis Not Included) - Child	$18	$23
D1204	Topical Application Of Fluoride (Prophylaxis Not Included) - Adult	$18	$23
D1206	Topical Fluoride Varnish; Therapeutic Application For Moderate To High Caries Risk Patients	$18	$23
D1351	Sealant - Per Tooth	$26	$32
D1510	Space Maintainer - Fixed - Unilateral	$177	$225
D1515	Space Maintainer - Fixed - Bilateral	$256	$351
D1520	Space Maintainer - Removable - Unilateral	$177	$225
D1525	Space Maintainer - Removable - Bilateral	$256	$351
D1550	Re-Cementation Of Space Maintainer	$33	$42
D1555	Removal Of Fixed Space Maintainer	$23	$29
D2140	Amalgam - One Surface, Primary Or Permanent	$59	$76
D2150	Amalgam - Two Surfaces, Primary Or Permanent	$75	$95
D2160	Amalgam - Three Surfaces, Primary Or Permanent	$90	$115
D2161	Amalgam - Four Or More Surfaces, Primary Or Permanent	$109	$138
D2330	Resin-Based Composite - One Surface, Aterior	$80	$101
D2331	Resin-Based Composite - Two Surfaces, Aterior	$104	$131
D2332	Resin-Based Composite - Three Surfaces, Aterior	$115	$147

ADA Codes	Description	Fee Amounts	
		General Dentist	Specialist
D2335	Resin-Based Composite - Four Or More Surfaces Or Involving Incisal Angle (Anterior)	$119	$151
D2390	Resin-Based Composite Crown, Aterior	$119	$151
D2391	Resin-Based Composite - One Surface, Posterior	$89	$113
D2392	Resin-Based Composite - Two Surfaces, Posterior	$112	$143
D2393	Resin-Based Composite - Three Surfaces, Posterior	$136	$173
D2394	Resin-Based Composite - Four Or More Surfaces, Posterior	$143	$182
D2510	Inlay - Metallic - One Surface	$402	$511
D2520	Inlay - Metallic - Two Surfaces	$479	$609
D2530	Inlay - Metallic - Three Or More Surfaces	$515	$655
D2542	Onlay - Metallic - Two Surfaces	$495	$628
D2543	Onlay - Metallic - Three Surfaces	$582	$739
D2544	Onlay - Metallic - Four Or More Surfaces	$605	$769
D2610	Inlay - Porcelain/Ceramic - One Surface	$434	$552
D2620	Inlay - Porcelain/Ceramic - Two Surfaces	$482	$613
D2630	Inlay - Porcelain/Ceramic - Three Or More Surfaces	$523	$663
D2642	Onlay - Porcelain/Ceramic - Two Surfaces	$504	$642
D2643	Onlay - Porcelain/Ceramic - Three Surfaces	$584	$743
D2644	Onlay - Porcelain/Ceramic - Four Or More Surfaces	$609	$774
D2650	Inlay - Resin-Based Composite - One Surface	$378	$480
D2651	Inlay - Resin-Based Composite - Two Surfaces	$420	$533
D2652	Inlay - Resin-Based Composite - Three Or More Surfaces	$454	$578
D2662	Onlay - Resin-Based Composite - Two Surfaces	$439	$557
D2663	Onlay - Resin-Based Composite - Three Surfaces	$507	$645
D2664	Onlay - Resin-Based Composite - Four Or More Surfaces	$530	$674

ADA Codes	Description	Fee Amounts	
		General Dentist	Specialist
D2710	Crown - Resin-Based Composite (Indirect)	$227	$290
D2712	Crown - 3/4 Resin-Based (Indirect)	$227	$290
D2720	Crown - Resin With High Noble Metal	$341	$435
D2721	Crown - Resin With Predominantly Base Metal	$341	$435
D2722	Crown - Resin With Noble Metal	$341	$435
D2740	Crown - Porcelain/Ceramic Substrate	$665	$846
D2750	Crown - Porcelain Fused To High Noble Metal	$652	$837
D2751	Crown - Porcelain Fused To Predominantly Base Metal	$576	$731
D2752	Crown - Porcelain Fused To Noble Metal	$615	$786
D2780	Crown - 3/4 Cast High Noble Metal	$620	$811
D2781	Crown - 3/4 Cast Predominantly Base Metal	$525	$668
D2782	Crown - 3/4 Cast Noble Metal	$584	$743
D2783	Crown - 3/4 Porcelain/Ceramic	$665	$846
D2790	Crown - Full Cast High Noble Metal	$620	$811
D2791	Crown - Full Cast Predominantly Base Metal	$525	$668
D2792	Crown - Full Cast Noble Metal	$584	$743
D2794	Crown - Titanium	$620	$811
D2910	Recement Inlay, Onlay, Or Partial Coverage Restoration	$47	$59
D2915	Recement Cast Or Prefabricated Post And Core	$47	$59
D2920	Recement Crown	$47	$59
D2930	Prefabricated Stainless Steel Crown - Primary Tooth	$146	$185
D2931	Prefabricated Stainless Steel Crown - Permanent Tooth	$158	$202
D2932	Prefabricated Resin Crown	$166	$212
D2933	Prefabricated Stainless Steel Crown With Resin Window	$166	$212
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	$166	$212

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D2940	Sedative Filling	$48	$60
D2950	Core Buildup, Including Any Pins	$103	$130
D2951	Pin Retention - Per Tooth, In Addition To Restoration	$27	$34
D2952	Cast Post And Core In Addition To Crown, Indirectly Fabricated	$228	$290
D2953	Each Additional Indirectly Fabricated Post - Same Tooth	$20	$20
D2954	Prefabricated Post And Core In Additioin To Crown	$144	$183
D2957	Each Additional Prefabricated Post - Same Tooth	$15	$15
D2960	Labial Veneer (Resin Laminate) - Chairside	$221	$280
D2961	Labial Veneer (Resin Laminate) - Laboratory	$328	$417
D2962	Labial Veneer (Porcelain Laminate) - Laboratory	$457	$581
D2971	Additional Procedures To Construct New Crown Under Existing Partial Denture Framework	$125	$125
D2980	Crown Repair, By Report	$119	$152
D3110	Pulp Cap - Direct (Excluding Final Restoration)	$33	$42
D3120	Pulp Cap - Indirect (Excluding Final Restoration)	$33	$42
D3220	Therapeutic Pulpotomy (Excluding Final Restoration) - Removal Of Pulp Coronal To The Dentinocemental Junction And Application Of Medicament	$99	$125
D3221	Pulpal Debridement, Primary And Permanent Teeth	$59	$75
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth (Excluding Final Restoration)	$104	$131
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth (Excluding Final Restoration)	$114	$144
D3310	Anterior (Excluding Final Restoration)	$410	$521
D3320	Bicuspid (Excluding Final Restoration)	$482	$613
D3330	Molar (Excluding Final Restoration)	$627	$798
D3331	Treatment Of Root Canal Obstruction; Non-Surgical Access	$123	$156
D3332	Incomplete Endodontic Therapy; Inoperable Or Fractured Tooth	$205	$261

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D3333	Internal Root Repair Of Perforation Defects	$123	$156
D3346	Retreatment Of Previous Root Canal Therapy - Anterior	$535	$680
D3347	Retreatment Of Previous Root Canal Therapy - Bicuspid	$618	$785
D3348	Retreatment Of Previous Root Canal Therapy - Molar	$748	$950
D3351	Apexification/Recalcification - Initial Visit (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	$123	$156
D3352	Apexification/Recalcification - Interim Medication Replacement (Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	$82	$104
D3353	Apexification/Recalcification - Final Visit (Includes Completed Root Canal Therapy - Apical Closure/Calcific Repair Of Perforations, Root Resorption, Etc.)	$287	$365
D3410	Apicoectomy/Periradicular Surgery - Anterior	$375	$477
D3421	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$454	$578
D3425	Apicoectomy/Periradicular Surgery - Molar (First Root)	$469	$596
D3426	Apicoectomy/Periradicular Surgery (Each Additional Root)	$168	$214
D3430	Retrograde Filling - Per Root	$83	$106
D3450	Root Amputation - Per Root	$245	$311
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	$207	$263
D3950	Canal Preparation And Fitting Of Preformed Dowel Or Post	$62	$78
D4210	Gingivectomy Or Gingivoplasty - Four Or More Contiguous Teeth or Bounded Teeth Spaces Per Quadrant	$292	$373
D4211	Gingivectomy Or Gingivoplasty - One To Three Contiguous Teeth Or Bounded Spaces Per Quadrant	$120	$152
D4240	Gingival Flap Procedure, Including Root Planing - Four Or More Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	$343	$436
D4241	Gingival Flap Procedure, Including Root Planing - One To Three Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	$240	$305
D4249	Clinical Crown Lengthening - Hard Tissue	$431	$550

ADA Codes	Description	Fee Amounts	
		General Dentist	Specialist
D4260	Osseous Surgery (Including Flap Entry And Closure) - Four Or More Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	$650	$826
D4261	Osseous Surgery (Including Flap Entry And Closure) - One To Three Contiguous Teeth Or Bounded Teeth Spaces Per Quadrant	$455	$578
D4263	Bone Replacement Graft - First Site In Quadrant	$195	$248
D4264	Bone Replacement Graft - Each Additional Site In Quadrant	$149	$190
D4266	Guided Tissue Regeneration - Resorbable Barrier, Per Site	$240	$304
D4267	Guided Tissue Regeneration - Nonresorbable Barrier, Per Site (Includes Membrane Removal)	$281	$357
D4268	Surgical Revision Procedure, Per Tooth	$120	$152
D4270	Pedicle Soft Tissue Graft Procedure	$461	$586
D4271	Free Soft Tissue Graft Procedure (Including Donor Site Surgery)	$484	$718
D4273	Subepithelial Connective Tissue Graft Procedures, Per Tooth	$565	$718
D4274	Distal or Proximal Wedge Procedure (When Not Performed In Conjunction With Surgical Procedures In The Same Anatomical Area)	$149	$190
D4275	Soft Tissue Allograft	$581	$862
D4276	Combined Connective Tissue And Double Pedicle Graft, Per Tooth	$537	$682
D4341	Periodontal Scaling And Root Planing - Four or More Teeth Per Quadrant	$124	$158
D4342	Periodontal Scaling And Root Planing - One To Three Teeth Per Quadrant	$87	$111
D4355	Full Mouth Debridement To Enable Comprehensive Evaluation And Diagnosis	$65	$83
D4910	Periodontal Maintenance	$69	$88
D5110	Complete Denture - Maxillary	$794	$1,009
D5120	Complete Denture - Mandibular	$794	$1,009
D5130	Immediate Denture - Maxillary	$838	$1,065
D5140	Immediate Denture - Mandibular	$838	$1,065
D5211	Maxillary Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	$589	$749

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D5212	Mandibular Partial Denture - Resin Base (Including Any Conventional Clasps, Rests And Teeth)	$589	$749
D5213	Maxillary Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	$870	$1,105
D5214	Mandibular Partial Denture - Cast Metal Framework With Resin Denture Bases (Including Any Conventional Clasps, Rests And Teeth)	$870	$1,105
D5225	Maxillary Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	$870	$1,105
D5226	Mandibular Partial Denture - Flexible Base (Including Any Clasps, Rests And Teeth)	$870	$1,105
D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (Including Clasps And Teeth)	$344	$437
D5410	Adjust Complete Denture - Maxillary	$39	$50
D5411	Adjust Complete Denture - Mandibular	$39	$50
D5421	Adjust Partial Denture - Maxillary	$39	$50
D5422	Adjust Partial Denture - Mandibular	$39	$50
D5510	Repair Broken Complete Denture Base	$120	$154
D5520	Replace Missing Or Broken Teeth - Complete Denture (Each Tooth)	$96	$122
D5610	Repair Resin Denture Base	$83	$106
D5620	Repair Cast Frame Work	$90	$114
D5630	Repair Or Replace Broken Clasp	$78	$99
D5640	Replace Broken Teeth - Per Tooth	$73	$93
D5650	Add Tooth To Existing Partial Denture	$96	$122
D5660	Add Clasp To Existing Partial Denture	$125	$159
D5670	Replace All Teeth And Acrylic On Cast Metal Framework (Maxillary)	$326	$415
D5671	Replace All Teeth And Acrylic On Cast Metal Framework (Mandibular)	$326	$415
D5710	Rebase Complete Maxillary Denture	$282	$358
D5711	Rebase Complete Mandibular Denture	$282	$358

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D5720	Rebase Maxillary Partial Denture	$261	$332
D5721	Rebase Mandibular Partial Denture	$261	$332
D5730	Reline Complete Maxillary Denture (Chairside)	$138	$175
D5731	Reline Complete Mandibular Denture (Chairside)	$138	$175
D5740	Reline Maxillary Partial Denture (Chairside)	$110	$141
D5741	Reline Mandibular Partial Denture (Chairside)	$110	$141
D5750	Reline Complete Maxillary Denture (Laboratory)	$237	$301
D5751	Reline Complete Mandibular Denture (Laboratory)	$237	$301
D5760	Reline Maxillary Partial Denture (Laboratory)	$205	$261
D5761	Reline Mandibular Partial Denture (Laboratory)	$205	$261
D5820	Interim Partial Denture (Maxillary)	$281	$357
D5821	Interim Partial Denture (Mandibular)	$281	$357
D5850	Tissue Conditioning, Maxillary	$78	$98
D5851	Tissue Conditioning, Mandibular	$78	$98
D6010	Surgical Placement Of Implant Body: Endosteal Implant	$1,300	$1,652
D6040	Surgical Placement: Eposteal Implant	$2,080	$2,643
D6050	Surgical Placement: Transosteal Implant	$1,300	$1,652
D6053	Implant/Abutment Supported Removable Denture For Completely Edentulous Arch	$1,191	$1,514
D6054	Implant/Abutment Supported Removable Denture For Partially Edentulous Arch	$1,305	$1,658
D6055	Dental Implant Supported Connecting Bar	$484	$633
D6056	Prefabricated Abutment - Includes Placement	$363	$474
D6057	Custom Abutment - Includes Placement	$502	$657
D6058	Abutment Supported Porcelain/Ceramic Crown	$998	$1,269
D6059	Abutment Supported Porcelain Fused To Metal Crown (High Noble Metal)	$978	$1,256

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D6060	Abutment Supported Porcelain Fused To Metal Crown (Predominantly Base Metal)	$864	$1,097
D6061	Abutment Supported Porcelain fused To Metal Crown (Noble Metal)	$923	$1,179
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$930	$1,217
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$788	$1,002
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$876	$1,115
D6065	Implant Supported Porcelain/Ceramic Crown	$998	$1,269
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$978	$1,256
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy, High Noble Metal)	$930	$1,217
D6068	Abutment Supported Retainer For Porcelain/Ceramic Fpd	$998	$1,269
D6069	Abutment Supported Retainer For Porcelain Fused to Metal Fpd (High Noble Metal)	$978	$1,256
D6070	Abutment Supported Retainer For Porcelain Fused to Metal Fpd (Predominantly Base Metal)	$864	$1,097
D6071	Abutment Supported Retainer For Porcelain Fused to Metal Fpd (Noble Metal)	$923	$1,179
D6072	Abutment Supported Retainer For Cast Metal Fpd (High Noble Metal)	$930	$1,217
D6073	Abutment Supported Retainer For Cast Metal Fpd (Predominantly Base Metal)	$788	$1,002
D6074	Abutment Supported Retainer For Cast Metal Fpd (Noble Metal)	$876	$1,115
D6075	Implant Supported Retainer For Ceramic Fpd	$998	$1,269
D6076	Implant Supported Retainer For Porcelain Fused to Metal Fpd (Titanium, Titanium Alloy Or High Noble Metal)	$978	$1,256
D6077	Implant Supported Retainer For Cast Metal Fpd (Titanium, Titanium Alloy Or High Noble Metal)	$930	$1,217
D6092	Recement Implant/Abutment Supported Crown	$47	$59
D6093	Recement Implant/Abutment Supported Fixed Partial Denture	$65	$83
D6094	Abutment Supported Crown - Titanium	$930	$1,217

ADA Codes	Description	Fee Amounts	
		General Dentist	Specialist
D6190	Radiographic/Surgical Implant Index, By Report	$149	$192
D6194	Abutment Supported Retainer Crown For Fpd- Titanium	$930	$1,217
D6205	Pontic - Indirect Resin-Based Composite	$227	$290
D6210	Pontic - Cast High Noble Metal	$620	$811
D6211	Pontic - Cast Predominantly Base Metal	$525	$668
D6212	Pontic - Cast Noble Metal	$584	$743
D6214	Pontic - Titanium	$620	$811
D6240	Pontic - Porcelain Fused To High Noble Metal	$652	$837
D6241	Pontic - Porcelain Fused To Predominantly Base Metal	$576	$731
D6242	Pontic - Porcelain Fused To Noble Metal	$615	$786
D6245	Pontic - Porcelain/Ceramic	$652	$837
D6250	Pontic - Resin With High Noble Metal	$652	$837
D6251	Pontic - Resin With Predominantly Base Metal	$576	$731
D6252	Pontic - Resin With Noble Metal	$615	$786
D6545	Retainer - Cast Metal For Resin Bonded Fixed Prosthesis	$241	$305
D6548	Retainer - Porcelain/Ceramic For Resin Bonded Fixed Prosthesis	$241	$305
D6600	Inlay - Porcelain/Ceramic, Two Surfaces	$482	$613
D6601	Inlay - Porcelain/Ceramic, Three Or More Surfaces	$523	$663
D6602	Inlay - Cast High Noble Metal, Two Surfaces	$479	$609
D6603	Inlay - Cast High Noble Metal, Three Or More Surfaces	$515	$655
D6604	Inlay - Cast Predominantly Base Metal, Two Surfaces	$479	$609
D6605	Inlay - Cast Predominantly Base Metal, Three Or More Surfaces	$515	$655
D6606	Inlay - Cast Noble Metal, Two Surfaces	$479	$609
D6607	Inlay - Cast Noble Metal, Three Or More Surfaces	$515	$655
D6608	Onlay - Porcelain/Ceramic, Two Surfaces	$504	$642

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D6609	Onlay - Porcelain/Ceramic, Three Or More Surfaces	$584	$743
D6610	Onlay - Cast High Noble Metal, Two Surfaces	$495	$628
D6611	Onlay - Cast High Noble Metal, Three Or More Surfaces	$582	$739
D6612	Onlay - Cast Predominantly Base Metal, Two Surfaces	$495	$628
D6613	Onlay - Cast Predominantly Base Metal, Three Or More Surfaces	$582	$739
D6614	Onlay - Cast Noble Metal, Two Surfaces	$495	$628
D6615	Onlay - Cast Noble Metal, Three Or More Surfaces	$582	$739
D6624	Inlay - Titanium	$479	$609
D6634	Onlay - Titanium	$495	$628
D6710	Crown - Indirect Resin-Based Composite	$227	$290
D6720	Crown - Resin With High Noble Metal	$341	$435
D6721	Crown - Resin With Predominantly Base Metal	$341	$435
D6722	Crown - Resin With Noble Metal	$341	$435
D6740	Crown - Porcelain/Ceramic	$665	$846
D6750	Crown - Porcelain Fused To High Noble Metal	$652	$837
D6751	Crown - Porcelain Fused To Predominantly Base Metal	$576	$731
D6752	Crown - Porcelain Fused To Noble Metal	$615	$786
D6780	Crown - 3/4 Cast High Noble Metal	$581	$766
D6781	Crown - 3/4 Cast Predominantly Base Metal	$525	$668
D6782	Crown - 3/4 Cast Noble Metal	$584	$732
D6783	Crown - 3/4 Porcelain/Ceramic	$665	$846
D6790	Crown - Full Cast High Noble Metal	$620	$811
D6791	Crown - Full Cast Predominantly Base Metal	$525	$668
D6792	Crown - Full Cast Noble Metal	$584	$743
D6793	Provisional Retainer Crown	$166	$212

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D6794	Crown - Titanium	$620	$811
D6930	Recement Fixed Partial Bridge	$65	$83
D6940	Stress Breaker	$174	$221
D6970	Cast Post And Core In Addition To Fixed Partial Denture Retainer, Indirectly Fabricated	$228	$290
D6972	Prefabricated Post And Core In Addition To Fixed Partial Denture Retainer	$144	$183
D6973	Core Build Up For Retainer, Including Any Pins	$103	$130
D6976	Each Additional Indirectly Fabricated Post - Same Tooth	$20	$20
D6977	Each Additional Prefabricated Post - Same Tooth	$15	$15
D6980	Fixed Partial Denture Repair, By Report	$120	$153
D6985	Pediatric Partial Denture, Fixed	$256	$351
D7111	Extraction, Coronal Remnants - Deciduous Tooth	$46	$59
D7140	Extraction, Erupted Tooth Or Exposed Root (Elevation And/Or Forceps Removal)	$66	$84
D7210	Surgical Removal Of Erupted Tooth Requiring Evaluation Of Mucoperiosteal Flap And Removal Of Bone And/Or Section Of Tooth	$128	$162
D7220	Removal of Impacted Tooth - Soft Tissue	$164	$209
D7230	Removal of Impacted Tooth - Partially Bony	$218	$277
D7240	Removal of Impacted Tooth - Completely Bony	$267	$339
D7241	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$293	$373
D7250	Surgical Removal Of Residual Tooth Roots (Cutting Procedure)	$130	$165
D7260	Oroantral Fistula Closure	$298	$378
D7261	Primary Closure Of A Sinus Perforation	$298	$378
D7280	Surgical Access Of An Unerupted Tooth	$218	$277
D7282	Mobilization Of Erupted Or Malpositioned Tooth To Aid Eruption	$304	$387
D7283	Placement Of Device To Facilitate Eruption Of Impacted Tooth	$86	$110

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D7285	Biopsy Of Oral Tissue - Hard (Bone, Tooth)	$241	$308
D7286	Biopsy Of Oral Tissue - Soft	$134	$171
D7288	Brush Biopsy - Transepithelial Sample Collection	$67	$86
D7310	Alveoloplasty In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	$113	$144
D7311	Alveoloplasty In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	$57	$72
D7320	Alveoloplasty Not In Conjunction With Extractions - Four Or More Teeth Or Tooth Spaces, Per Quadrant	$148	$188
D7321	Alveoloplasty Not In Conjunction With Extractions - One To Three Teeth Or Tooth Spaces, Per Quadrant	$104	$13
D7410	Excision Of Benign Lesion Up To 1.25 Cm	$165	$209
D7411	Excision Of Benign Lesion Greater Than 1.25 Cm	$239	$303
D7412	Excision Of Benign Lesion, Complicated	$264	$334
D7413	Excision Of Malignant Lesion Up To 1.25 Cm	$165	$209
D7414	Excision Of Malignant Lesion Greater Than 1.25 Cm	$239	$303
D7415	Excision Of Malignant Lesion, Complicated	$264	$334
D7440	Excision Of Malignant Tumor - Lesion Diameter Up To 1.25 Cm	$207	$264
D7441	Excision Of Malignant Tumor - Lesion Diameter Greater Than 1.25 Cm	$219	$278
D7450	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	$204	$259
D7451	Removal Of Benign Odontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	$207	$263
D7460	Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Up To 1.25 Cm	$175	$223
D7461	Removal Of Benign Nonodontogenic Cyst Or Tumor - Lesion Diameter Greater Than 1.25 Cm	$371	$472
D7465	Destruction Of Lesion(s) By Physical Or Chemical Method, By Report	$83	$105
D7471	Removal Of Lateral Exostosis - (Maxilla Or Mandible)	$262	$333

ADA Codes	Description	Fee Amounts	
		General Dentist	Specialist
D7472	Removal Of Torus Palatinus	$262	$333
D7473	Removal Of Torus Mandibularis	$262	$333
D7485	Surgical Reduction Of Osseous Tuberosity	$262	$333
D7510	Incision And Drainage Of Abscess - Interoral Soft Tissue	$86	$109
D7511	Incision And Drainage Of Abscess - Interoral Soft Tissue - Complicated (Includes Drainage Of Multiple Facial Spaces)	$95	$120
D7520	Incision And Drainage Of Abscess - Extraoral Soft Tissue	$103	$131
D7521	Incision And Drainage Of Abscess - Extraoral Soft Tissue - Complicated (Includes Drainage Of Multiple Facial Spaces)	$114	$144
D7960	Frenulectomy (Frenectomy Or Frenotomy) - Separate Procedure	$197	$250
D7963	Frenuloplasty	$315	$400
D7970	Excision Of Hyperplastic Tissue - Per Arch	$165	$209
D7971	Excision Of Pericoronal Gingiva	$93	$119
D7972	Surgical Reduction Of Fibrous Tuberosity	$131	$167
D8010	Limited Orthodontic Treatment Of The Primary Dentition	N/A	$640
D8020	Limited Orthodontic Treatment Of The Transitional Dentition	N/A	$640
D8030	Limited Orthodontic Treatment Of The Adolescent Dentition	N/A	$640
D8040	Limited Orthodontic Treatment Of The Adult Dentition	N/A	$640
D8050	Interceptive Orthodontic Treatment Of The Primary Dentition	N/A	$895
D8060	Interceptive Orthodontic Treatment Of The Transitional Dentition	N/A	$895
D8070	Comprehensive Orthodontic Treatment Of The Transitional Dentition	N/A	$2,558
D8080	Comprehensive Orthodontic Treatment Of The Adolescent Dentition	N/A	$2,558
D8090	Comprehensive Orthodontic Treatment Of The Adult Dentition	N/A	$2,558
D8210	Removable Appliance Therapy	$197	$250
D8220	Fixed Appliance Therapy	$197	$250
D8660	Pre-Orthodontic Treatment Visit	N/A	$250

ADA Codes	Description	Fee Amounts General Dentist	Specialist
D8670	Periodic Orthodontic Treatment Visit (As Part Of Contract)	N/A	$107
D8680	Orthodontic Retention (Removal Of Appliances, Construction And Placement Of Retainer(s))	N/A	$425
D9110	Palliative (Emergency) Treatment Of Dental Pain - Minor Procedure	$50	$63
D9120	Fixed Partial Denture Sectioning	$98	$125
D9220	Deep Sedation/General Anesthesia - First 30 Minutes	$193	$245
D9221	Deep Sedation/General Anesthesia - Each Additional 15 Minutes	$78	$99
D9230	Analgesia, Anxiolysis, Inhalation Of Nitrous Oxide	$ 27	$34
D9241	Intravenous Conscious Sedation/Analgesia - First 30 Minutes	$193	$245
D9242	Intravenous Conscious Sedation/Analgesia - Each Additional 15 Minutes	$78	$99
D9248	Non-Intravenous Conscious Sedation	$183	$233
D9310	Consultation - Diagnostic Service Provided By Dentist Or Physician Other Than Requesting Dentist Or Physician	$60	$77
D9430	Office Visit For Observation (During Regularly Scheduled Hours) - No Other Services Performed	$29	$36
D9440	Office Visit - After Regularly Scheduled Hours	$53	$72
D9610	Therapeutic Parenteral Drug, Single Administration	$ 26	$32
D9612	Therapeutic Parenteral Drugs, Two Or More Administrations, Different Medications	$39	$48
D9940	Occlusal Guard, By Report	$325	$413
D9942	Repair And/Or Relining Of An Occlusal Guard	$49	$62
D9951	Occlusal Adjustment - Limited	$56	$71
D9952	Occlusal Adjustment - Complete	$150	$191

Alternate Treatment

If more than one type of service can be used to treat a dental condition, *we* have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by *us.* For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

Proof of Claim

So that *we* may pay benefits accurately, the *covered person* or his or her *dentist* must provide *us* with information that is acceptable to *us.* This information may, at *our* discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If *we* don't receive the necessary information, *we* may pay no benefits, or minimum benefits. However, if *we* receive the necessary information within 15 months of the date of service, *we* will redetermine the *covered person's* benefits based on the new information. Failure to furnish such proof within such time will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

Pre-Treatment Review

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

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

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

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

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

B498.0003-R

Benefits From Other Sources

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

B498.0005-R

The Benefit Provision - Qualifying For Benefits

B498.0072-R

Penalty For Late Entrants

During the first 6 months that a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group IV Services.

Charges for the services we don't cover under this provision are not considered to be covered charges under this *plan,* and therefore can't be used to meet this *plan's* deductibles.

We don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan.*

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

B498.0231-R

How We Pay Benefits For Group I, II And III Non-Orthodontic Services

There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate.*

A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *preferred provider.* A *benefit year* deductible of $50.00 applies to Group II and III services provided by a *non-preferred provider.* Each *covered person* must have covered charges from these service groups which exceed each applicable deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Covered charges used to satisfy a *covered person's* Non-PPO deductible are also credited toward his or her PPO deductible. And covered charges used to satisfy a *covered person's* PPO deductible are also credited toward his or her Non-PPO deductible.

Once a *covered person* meets the deductible, *we* pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year.*

B498.0177-R

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,000.00.

B498.0192-R

The Benefit Provision - Qualifying For Benefits

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

B498.2041-R

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year,* receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold,* he or she may be entitled to a Reward.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider,* he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider.*

Rewards can accrue and are stored in the *covered person's Bank.* If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank.* The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum.*

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this *plan's Rollover Threshold, Reward,* and *Bank Maximum* are:

- *Rollover Threshold* $500.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $350.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $250.00
- *Bank Maximum* $1,000.00

If this *plan's* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year.* And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year.* In either case:

- only claims incurred on or after January 1 will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of this *plan* called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year,* this rollover provision will not apply to the *covered person* until the next *benefit year,* and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold;* and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a *covered person's* accrued *Reward* .

"Bank Maximum" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank.*

"Reward" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold.*

"Rollover Threshold" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward.*

B498.2037-R

How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services.

We pay for Group IV covered charges at the applicable *payment rate.* There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider.*

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* limit what *we* pay for orthodontic services to the lifetime payment of $1,000.00. What *we* pay is based on all of the terms of 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 benefits *we* pay for *orthodontic treatment* won't be charged against a *covered person's benefit year* payment limits that apply to all other services.

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 fixed and removable *appliances* and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment,* with associated: (i) fabrication and insertion of any and all fixed *appliances;* and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic *appliances* made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, *appliances* or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in *orthodontic treatment* necessitated by any kind of accident; (d) replacement or repair of orthodontic *appliances* damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate orthodontic treatment; and (g) *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 limit under this *plan.*

B498.0057-R

Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year.* Once this happens, *we* pay benefits for covered charges incurred by any *covered person* in that *covered family,* at the applicable *payment rate* for the rest of that *benefit year.* The charges must be incurred while the person is insured. What *we* pay is based on this *plan's payment limits* and to all of the terms of this *plan.*

B498.0073-R

Payment Rates

Benefits for covered charges are paid at the following *payment rates:*

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 50%
- Benefits for Group II Services performed by a *non-preferred provider* 40%
- Benefits for Group III Services performed by a *preferred provider* 50%
- Benefits for Group III Services performed by a *non-preferred provider* 30%
- Benefits for Group IV Services performed by a *preferred provider* 50%
- Benefits for Group IV Services performed by a *non-preferred provider* 50%

B498.0080-R

After This Insurance Ends

We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan, we'll* pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis,* if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

B498.0233-R

Extended Dental Expense Benefits

If a *covered person* is totally disabled on the date this *plan* ends, we extend dental expense benefits for that *covered person* under this *plan* as explained below.

We only extend benefits for covered charges for dental procedures, if the procedures: (a) are in connection with a specific accident or illness incurred while the policy was in effect; and (b) are performed within 90 days after the date the *covered person's* insurance ends.

The extension ends 90 days after the *covered person's* insurance ends.

We don't grant an extension if the person's insurance ended because he failed to make required payments to his employer. And what we pay is based on all terms of this *plan.*

An employee is totally disabled if, due to sickness or injury, he can't perform the main duties of his occupation. A covered dependent is totally disabled if, due to sickness or injury, the covered dependent can't perform the normal activities of someone of the same age. The employee must submit evidence to us that he or his dependent is totally disabled, if we request it.

B498.1609-R

Special Limitations

B498.0138-R

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* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

B498.0133-R

If This Plan Replaces The Prior Plan

This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person.*

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan;* and (b) for which extraction benefits were paid by the *prior plan.*
- **Deductible Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's* deductibles required under this *plan,* by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- ***Benefit Year* Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan.* The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.
- **Orthodontic Payment Limit Credit** - We reduce a *covered person's* orthodontic *payment limits* by the amounts paid or payable under the *prior plan.* The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

B498.0129-R

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- 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.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this *plan.*
- 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.

- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty. However, we will cover cosmetic services for newly born children needed to treat medically diagnosed congenital defects and birth abnormalities.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis;* unless(1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- 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.
- The replacement of extracted or missing third molars/wisdom teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- 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, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- 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.
- 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.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a *dentist.* And they must be usual and necessary treatment for a dental condition.

B490.0048-R

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, 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 patient'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 limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the same visit.

B498.4802-R

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 - bilateral
- Removable - unilateral

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

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 6 months after insertion.

B498.0164-R

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 films including bitewings
Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal films - single films

B498.0165-R

Dental Sealants

Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

B498.0166-R

Group II - Basic Dental Services
(Non-Orthodontic)

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. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

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: dentures, crowns, bridges, inlays or onlays.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

Restorative Services

Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

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.

Silicate cement, per restoration
Composite resin

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 24 consecutive month period. 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.

B498.2780-R

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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 relines 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 reline done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 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 6 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 1 treatment, per arch, in any 12 consecutive month period.

B498.1122-R

Other Services Injectable antibiotics needed solely for treatment of a dental condition.

B498.0224-R

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 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

B498.1132-R

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.

Vital pulpotomy, only when root canal therapy is not the definitive treatment
Gross pulpal debridement
Pulpal therapy, limited to primary teeth only coinsurance
Root Canal Treatment
Root canal therapy
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

Other Endodontic Services
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

B498.0209-R

Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

B498.0210-R

Non-Surgical Extractions

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

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

Surgical Extractions

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

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

Other Oral Surgical Procedures

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

Alveoloplasty, per quadrant
Removal of exostosis, maxilla or mandible
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
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
Removal of upper or lower torus
Oroantral fistula closure
Sialolthotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

B498.0414-R

General Anesthesia

General anesthesia, intramuscular sedation, intravenous sedation, non intravenous sedation or inhalation sedation, including 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 the "Other Oral Surgical Procedures" section of this *plan.*

B498.0225-R

Group IV - Orthodontic Services

Orthodontic Services

Any covered Group I, II or III service in connection with *orthodontic treatment.*

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment,* Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment,* including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

B498.0071-R

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered By This Plan

A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

(a) he or she receives services or supplies from a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) 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 plan. 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 plan, access to the network discounts ends.

B499.0077-R

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 PPO, 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 PPO network, even if such services are not covered by the plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions, such as dental implants.

B499.0079-R

CERTIFICATE AMENDMENT

The certificate is amended as follows:

The Dental Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

B489.0422-R

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follow when titanium or high noble metal (gold) is used in a *dental prosthesis.*

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a *dental prosthesis,* the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

This rider is part of the Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

B531.0029-R

COORDINATION OF BENEFITS

Important Notice This section applies to all group health benefits under this plan, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

Purpose When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

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

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

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans.

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

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

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

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

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

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

Hospital Indemnity Benefits This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of $200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; (6) medical benefits under group or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

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

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

This Plan This term means the group health benefits provided under this group plan.

B550.0087-R

Order Of Benefit Determination

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

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

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

This Plan **always** pays secondary to any motor vehicle policy available to a covered person, including any medpay, PIP, No Fault or any plan or program which is required by law. All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

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

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

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

(1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

(2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

(3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

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

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

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

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

B550.0088-R

Effect On The Benefits Of This Plan

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

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

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

SUBROGATION AND RIGHT OF RECOVERY

Notice This section applies to any health care or loss of earnings benefits under this plan.

Purpose When a covered person has the right to recover amounts paid by this plan for health care or loss of earnings benefits, this plan also has certain rights. These are explained below.

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

- **Covered Person:** This term means any employee or dependent on whose behalf this plan pays health care or loss of earnings benefits. It includes the parent or guardian of any such covered employee or dependent who is a minor or incompetent.
- **Health Care:** This term means any: (a) major medical; (b) prescription drug; (c) dental; or (d) vision benefits.
- **Insurance Coverage:** This term means any insurance which provides coverage for: (a) medical expense payments; or (b) liability. This includes, but is not limited to: (i) uninsured motorist coverage; (ii) underinsured motorist coverage; (iii) personal umbrella coverage; (iv) medical payments coverage; (v) workers compensation coverage; (vi) no-fault automobile insurance coverage; or (vii) any first party insurance.
- **Third Party:** This term means any party actually, possibly, or potentially responsible for making any payment to a covered person due to the covered person's injury, sickness or condition. This term also means such party's: (a) the liability insurer; or (b) any insurance coverage. But, this term does not mean: (i) this plan; or (ii) the covered person.

Subrogation When this plan pays a benefit, it will immediately be subrogated to the covered person's rights of recovery from any third party to the full extent of benefits paid.

Recovery If a covered person receives a payment from any third party or insurance coverage due to an injury, sickness or condition, this plan has the right to recover from, and be repaid by, the covered person for all amounts this plan has paid and will pay due to that injury, sickness or condition, from such payment, up to and including the full amount he or she receives from any third party or insurance coverage.

Constructive Trust The covered person must serve as a constructive trustee over the funds that constitute payment from any third party or insurance coverage due to his or her injury, sickness or condition. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. If the covered person fails to hold such funds in trust, it will be deemed a breach of his or her fiduciary duty to the plan.

Lien Rights This plan will have a lien to the extent of benefits this plan paid due to the covered person's injury, sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or otherwise, including from any insurance coverage, that a covered person receives due to his or her injury, sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by this plan. This includes, but is not limited to: (a) the covered person; (b) the covered person's representative or agent; (c) the third party; (d) the third party's insurer, representative or agent; and (e) any other source who holds such funds.

First Priority Claim This plan's recovery rights are a first priority claim against all third parties or insurance coverage and are to be paid to the plan before any other claim for the covered person's damages. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. This plan will be entitled to full repayment on a first dollar basis from any third party's or insurance coverage's payments, even if such payment to the plan will result in a recovery to the covered person which is not sufficient: (i) to make him or her whole; or (ii) to compensate him or her in part or in whole for the damages sustained. This plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue his or her damage claim.

Applicable To All Settlements And Judgements This plan is entitled to full recovery regardless of whether: (a) any liability for payment is admitted by a third party; or (b) the settlement or judgement received by the covered person identifies the benefits the plan paid. This plan is entitled to recover from any and all settlements or judgements, even those designated as: (i) pain and suffering; or (ii) non-economic damages only.

Cooperation The covered person must fully cooperate with this plan's efforts to recover the benefits it paid. He or she must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his or her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, sickness or condition sustained by him or her. He or she, and his or her agents, must provide all information requested by the plan or its representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as the plan or its representative may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against him or her.

The covered person must do nothing: (a) to prejudice this plan's rights as described in this section; or (b) to prejudice the plan's ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this plan. Failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery obtained by the covered person may result in the termination of benefits or the instigation of legal action against him or her.

The plan or its representative has the right to conduct an investigation regarding the injury, sickness or condition to identify any third party. The plan reserves the right to notify the third party and his or her agents of this plan's lien. Agents include, but are not limited to: (a) insurance companies; and (b) attorneys.

Interpretation In the event that any claim is made that any part of this section is ambiguous, or questions arise as to the meaning or intent of any of its terms, the plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this section.

Jurisdiction Any legal action or proceeding with respect to this section may be brought in any court of competent jurisdiction as the plan may choose. The covered person must submit to each such jurisdiction and waive whatever rights may correspond to him or her by reason of his or her present or future domicile.

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

B900.0118-R

Active Orthodontic means an *appliance,* like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

B750.0663-R

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

B750.0664-R

Appliance means any dental device other than a *dental prosthesis.*

B750.0665-R

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

B750.0666-R

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist:* restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

B750.0667-R

Covered Family means an employee and those of his or her dependents who are covered by this *plan.*

B750.0668-R

Covered Person means an employee or any of his or her covered dependents.

B750.0669-R

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

B750.0670-R

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

B750.0671-R

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

B900.0003-R

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

B750.0015-R

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

B750.0672-R

Employee means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

B750.0006-R

Employer means a participating employer in the AFFILIATED PHYSICIANS & EMPLOYERS MASTER TRUST.

B900.0051-R

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

B900.0004-R

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 24 hours per week), at his *employer's* place of business.

B750.0230-R

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents,* but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents.*

B900.0006-R

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan,* and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

B750.0673-R

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

B900.0008-R

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

B750.0674-R

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

B750.0675-R

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

B750.0676-R

Payment Rate means the percentage rate that this *plan* pays for covered services.

B750.0677-R

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

B750.0679-R

Plan means the Guardian group dental plan purchased by the Trustees of the Affiliated Physicians & Employers Master Trust.

B750.0678-R

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

B750.0680-R

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan.* To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

B750.0681-R

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

B750.0682-R

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

B750.0683-R

STATEMENT OF ERISA RIGHTS

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.

The Guardian's Responsibilities

B800.0048-R

The dental expense benefits provided by this plan are funded solely by the employer. The benefits **are not** guaranteed by a policy of insurance issued by Guardian. Guardian does supply administrative services, such as claims services, including the payment of claims, preparation of employee benefit booklets, and changes to such benefit booklets.

B800.0064-R

The Guardian is located at 7 Hanover Square, New York, New York 10004.

B800.0049-R

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Administrator with respect to processing claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in your benefit booklet, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA")

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non-urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

Timing For Initial Benefit Determination

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

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

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

Post-Service Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

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

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided(a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and

- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

Urgent Care Claims. Guardian will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

Pre-Service Claims. Guardian will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

Post-Service Claims. Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

Alternative Dispute Options

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time.

When this *plan* ends, you may be eligible to continue your coverage. Your rights, if any, upon termination of the *plan* are explained in this benefit booklet.

B800.0068-R