YOUR GROUP INSURANCE PLAN BENEFITS

THE COUNTY OF GALVESTON
CLASS 0001
DENTAL, VISION

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company. If You don't, You may lose Your right to appeal.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

To get information or to file a complaint with your insurance company or HMO:

Call: (toll-free) 1-888-GUARDIAN (1-888-482-7342)
Online: www.guardiananytime.com/contact-us
Email: corporate_inquiries@glic.com
Mail: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439
Online: www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tambien debe presentar una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

Para obtener informacion o para presentar una queja ante su compania de seguros:

Llame: (telefono gratuito) 1-888-GUARDIAN (1-888-482-7342)
En linea: www.guardiananytime.com/contact-us
Correo electronico: corporate_inquiries@glic.com
Direccion postal: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:
Llame: 1-800-252-3439
En linea: www.tdi.texas.gov
Correo electronico: ConsumerProtection@tdi.texas.gov
Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-R-STK-90-3 B110.0023

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IMPORTANT NOTICE

The insurance policy under which this certificate is issued is not a policy of Workers' Compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the Workers' Compensation system.

CGP-3-R-COMP-TX-92 B120.0015

Options A , B

GENERAL PROVISIONS

As used in this booklet:

"Covered person" means an *employee* or a dependent insured by this *plan.*

"Employer" means the *employer* who purchased this *plan.*

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *employer.*

"You" and "your" mean an *employee* insured by this *plan.*

CGP-3-R-GENPRO-90 B160.0012

Options A , B

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90 B160.0004

Options A , B

Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this *plan* replaces a plan your *employer* had with another insurer, we may rescind the *employer's plan* based on misrepresentations made by the *employer* or an *employee* in a signed application for up to two years from the effective date of this *plan.*

CGP-3-R-INCY-90 B160.0003

Dental Claims Provisions

Your right to make a claim for any dental benefits provided by this *plan,* is governed as follows:

Notice You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made for one of your *covered dependents,* his or her name should also be noted.

Proof Of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

Late Notice Of Proof We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

Payment Of Benefits We'll pay all dental benefits to which you're entitled within 60 days after we receive written proof of loss.

We pay all dental benefits to you, if you're living. If you're not living, we have the right to pay all dental benefits to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services.

When you file proof of loss, you may direct us, in writing, to pay dental benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

Limitations Of Actions You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

Workers' Compensation The dental benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CGP-3-R-AHC-90-TX B160.0072

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87 B240.0044

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87 B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

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 coverages which apply to loss of life, or to loss of income due to disability. These coverages 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) a covered active employee or qualified retiree; (b) the spouse of a covered active employee or qualified retiree; or (c) the dependent child of a covered active employee or qualified retiree. A child born to, or adopted by, the covered active employee or qualified retiree 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 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 premium charge 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.

Special Continuance for Retired Employees and their Dependents

If your group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the employer, you may elect to continue such benefits, provided that:

(a) you are or become a retired employee on or before the date group health benefits end; and

(b) you and your dependents were covered for group health benefits under this plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for your lifetime. After your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for you and your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If you die before the bankruptcy proceeding under Title 11 of the United States Code, your surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceedings. The continuation can last for your surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.

CGP-3-R-COBRA-96-1 B235.0609

Options A , B

If You Die While Insured

If you die while insured, 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".

CGP-3-R-COBRA-96-2 B235.0075

Options A , B

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 an insured 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 by a qualified continuee 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.

CGP-3-R-COBRA-96-3 B235.0178

Options A , B

Your Employer's Responsibilities

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

Your employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) your death; (b) termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) Medicare entitlement; or (d) if you are a retired employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to the employer. Upon receipt of notice of a qualifying event from your employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan's group health benefits no later than 14 days after receipt of notice.

If your employer is also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, your employer must provide notice to a qualified continuee of the right to continue this plan's group health benefits within 44 days of the qualifying event.

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.

Your Employer's Liability

Your employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) he or she fails to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) he or she fails to notify the qualified continuee of his or her continuation rights, as described above.

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 pay his or her first premium in a timely manner.

The subsequent premiums 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 premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured 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 premium charge 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 pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A qualified continuee's premium 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 premium 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 premium that must be paid; 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 an insured 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 premium 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.

CGP-3-R-COBRA-96-4 B235.0198

Options A , B

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.

CGP-3-R-COBRA-96-4 B235.0195

YOUR CONTINUATION RIGHTS

Important Notice

This section does not apply to coverages which provide benefits for loss of income due to disability. All other coverages under the group plan are affected by this section, and are hereafter referred to as "group coverage."

Continuation of Coverage During a Labor Dispute

If A Work Stoppage Occurs A labor dispute may result in a work stoppage which causes your group coverage to end. If this happens, you have the right to continue your group coverage for yourself during the work stoppage, for up to 6 months.

How To Continue Group Coverage To continue your group coverage you must make timely payment of the total premium, including any portion of the premium your employer was paying before work stopped, to the union representing you. If you fail to pay a premium on time, you waive your right to continue under this section.

The Responsibilities of the Union For your group coverage to continue, the union representing you must do the following:

(a) collect the premium payments made by you; and

(b) make timely payment of the collected premiums to us.

If any such union, after timely receipt of your premium, fails to pay us on your behalf, thereby causing your group coverage to end, then such union will be liable to you for your benefits, to the same extent as, in place of, us.

The Premium The premium you must pay for continued group coverage will be at the rate that applies to the class of employees to which you belonged on the day work stopped. But, we have the right to increase this rate by up to 20% of any higher amount approved by the Insurance Commissioner, to allow for increased costs and risks caused by this continued coverage. We may do this at any time during the continuation. Nothing in this section alters our right to change premium rates according to the "Premiums" section of the group plan.

When This Continuation Starts Group coverage continued under this section starts on the day work stopped. But, if a premium that was due before the work stoppage began is unpaid at the time work stopped, then payment of such premium before the next premium due date will be required for this continuation to take effect.

When This Continuation Ends Your continued coverage ends on the first of the following:

(a) the end of the 6 month continuation period;

(b) when you enter full-time employment with another employer;

(c) the day the work stoppage ends;

(d) at the end of the period for which the last premium payment is made, if you stop paying premium;

(e) the date you stop being eligible as defined in the group plan, for reasons other than not meeting "actively at work" or "full-time" requirements.

CGP-3-R-CC-LD-1 B240.0001

Options A , B

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Options A , B

Employee Coverage

Eligible Employees To be eligible for *employee* coverage you must be an active *full-time employee* or a *qualified retiree.* 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.

CGP-3-EC-90-1.0 B489.0123

Options A , B

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.

CGP-3-EC-90-1.0 B489.0137

Options A , B

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 unless you are a *qualified retiree,* 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 an active *full-time employee* and 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.

If you are a *qualified retiree,* you can not be confined in a health care facility on the scheduled effective date of coverage. If you are confined on that date, we will postpone your coverage until the day after you are discharged. And you must also have met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

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.

CGP-3-EC-90-2.0 B489.0067

Options A , B

When Your Coverage Ends

If you are an active *full-time employee,* 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 (except for *qualified retirees),* 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.

CGP-3-EC-90-3.0 B489.0742

Options A , B

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.

CGP-3-EC-90-3.0 B449.0727

Options A , B

Dependent Coverage

B200.0271

Options A , B

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

CGP-3-DEP-90-2.0 B489.0480

Options A , B

Adopted Children, Step-Children and Grandchildren

An *employee's* "dependent children" include: (a) his or her legally adopted children; (b) his or her grandchildren who are dependents for federal income tax purposes at the time application for coverage of the grandchildren are made; and (c) his or her step-children.

We treat a child as legally adopted from the time the child is placed in the 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.

CGP-3-DEP-90-3.0 B489.0483

Options A , B

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.

CGP-3-DEP-90-4.0 B449.0042

Options A , B

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.

CGP-3-DEP-90-5.0 B200.0749

Options A , B

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.

CGP-3-DEP-90-6.0 B489.0254

Options A , B

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.

CGP-3-DEP-90-7.0 B200.0692

Options A , B

Newborn Children

We cover an *employee's* newborn child for dependent benefits, from the moment of birth, if the *employee* is already insured for dependent coverage when the child is born. If the *employee* does not have dependent coverage when the child is born, we cover the newborn child, for dependent benefits, for the first 31 days from the moment of birth. To continue the child's dependent benefits past the first 31 days, the *employee* must notify us in writing within 31 days of the child's birth.

CGP-3-DEP-90-8.0 B489.0178

Options A , B

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.

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.

CGP-3-DEP-90-9.0 B489.0920

Options A , B

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.

CGP-3-DEP-90-9.0 B489.1153

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.

But, at the end of such coverage, continuation and conversion rights, if any, to which the domestic partner and his or her dependent children may be entitled, will be available. Read "Continuation Rights" and "Converting This Group Health Insurance" to find out what is allowed under this plan and how it works. The domestic partner and his or her children will be not eligible for survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section.

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.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-DMST-96-WI B210.0055

Options A , B

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.

- **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

CGP-3-DENT-HL-90 B497.0075

Options A , B

- **Payment Rates:**

  For Group I Services 100%
  For Group II Services 80%
  For Group III Services 50%

CGP-3-DENT-HL-90 B497.0087

Option A

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

  For Group I, II and III 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.

CGP-3-DENT-HL-90 B497.1431

Option B

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

  For Group I, II and III Services . . . . Up to $2,000.00

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.

CGP-3-DENT-HL-90 B497.1431

Options A , B

Once each year, during the group enrollment period, you may elect to enroll in one of the dental expense *plan* options offered by your employer. The group enrollment period is a time period agreed to by your employer and us. Coverage starts on the first day of the month that next follows the date of enrollment. You and your eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.

Once each year, during a special election period you may select to transfer to another dental expense plan option offered by your employer. The special election period is a time period agreed to by your employer and us. Coverage under the new plan option starts of the first day of the month that follows election. Coverage under the former plan option ends on that date.

The group enrollment period and the special election periods are time periods agreed to by your employer and us. Such open enrollment period and special election period may occur during the same time period.

CGP-3-DENT-HLTS B497.2409

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.

CGP-3-DG2000 B498.0007

Options A , B

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in this *plan's* List of Covered Dental Services. 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.

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.

By reasonable, *we* mean the charge is the *dentist's* usual charge for the service furnished. By customary, *we* mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists.* But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

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 procedure 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. 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.

CGP-3-DGY2K-CC-TX B498.0389

Appeal Process

Definitions

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

Adverse Determination This term means a determination by a utilization review agent(URA) that the health care services provided or proposed to be provided to the *covered person* are not *medically necessary* or are experimental or investigational.

Certification This term means a determination that the health care services being provided or proposed to be provided to a *covered person* meet the criteria for *medical necessity* and appropriateness.

Clinical Peer This term means a *dentist* or health care professional in the same or similar specialty, who typically manages the medical condition, procedure or treatment under review.

Concurrent Review This term means a utilization review conducted for a currently in process course of treatment.

Department This term means the Texas Department of Insurance.

Emergency Care This term means health care services provided in a *hospital* emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson who has an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (a) placing a *covered person's* health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

External Review This term means the review of an adverse determination by an independent review organization(IRO).

Life-Threatening This term means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted. A life-threatening condition exists if a prudent layperson who has an average knowledge of medicine and health would believe that his or her disease or condition is a life-threatening condition.

Prospective Review This term means a utilization review conducted prior to a course of treatment.

Retrospective Review This term means the utilization review process of reviewing the medical necessity and reasonableness of health care that has been provided to a *covered person.*

Utilization Review This term includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Working Day This term means a weekday. It excludes: (a) New Years Day; (b) Memorial Day; (c) Fourth of July; (d) Labor Day; (e) Thanksgiving Day; and (f) Christmas Day.

Utilization Review Determinations

When the initial determination is certification, written notification will be sent to a *covered person* and the *covered person's* health care provider within two working days of making the determination.

The URA will make an initial determination in a prospective review within three working days of receipt of all information needed to complete the review.

The URA will make an initial determination in a concurrent review within three working days of receipt of all information needed to complete the review.

The URA will make an initial determination in a retrospective review within thirty days of receipt of all information needed to complete the review. This period may be extended once by the URA for a period not to exceed 15 days, if the URA:

(a) determines that an extension is necessary due to matters beyond the URA's control; and

(b) notifies the provider of record and the *covered person* before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the URA expects to make a determination.

If the extension is required because of the failure of the provider of record or the *covered person* to submit information necessary to reach a determination on the request, the notice of extension must:

(a) specifically describe the required information necessary to complete the request; and

(b) give the provider of record and the *covered person* at least 45 days from the date of receipt of the notice of extension to provide the specified information.

If the period for making the determination under this section is extended because of the failure of the provider of record or the *covered person* to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the URA sends the notification of the extension to the provider of record or the *covered person* until the earlier of:

(a) the date on which the provider of record or the *covered person* responds to the request for additional information; or

(b) the date by which the specified information was to have been submitted.

Notice of adverse determination will include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description of the source of the screening criteria that were used in making the determination;

(4) a description of the complaint and appeal process; and

(5) the independent review notification procedures, and the independent review request form.

For life-threatening conditions, notice of adverse determination will be given within the time frames shown above. In circumstances involving a life-threatening condition, the *covered person,* person acting on the *covered person's* behalf, or the *covered person's* provider of record is entitled to immediate external appeal by independent review and is not required to comply with procedures for reconsideration or internal appeals.

CGP-3-DGY2K-APP-TX-10 B498.4839

Options A , B

Internal Appeals

A *covered person,* a person acting on the *covered person's* behalf, or the *covered person's doctor* or health care provider may appeal an adverse determination orally or in writing.

Standard Appeal The request for standard appeal should be made or sent to the URA or to:

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 981573
El Paso, TX 79998-1573

Within five working days from receipt of a written appeal, a letter of acknowledgment will be sent to the appealing party. The letter will include the date the request for appeal was received, and a list of any documentation the appealing party is required to submit to support his or her request.

A licensed *doctor* or *dentist will review the appeal and render a decision.*

Within five working days of receipt of an oral request for standard appeal, an appeal form will be mailed to the appealing party.

A licensed *doctor* or *dentist* will review the appeal and render a decision.

Notification of that decision will be mailed to the *covered person* or a person acting on behalf of the *covered person* and to the *covered person's* health care provider within 30 days of receipt of the request for standard appeal.

If the appeal is denied, the notice will include:

(1) a statement of the specific reasons for the resolution;

(2) the clinical basis for such decision;

(3) the specialization of any *doctor* or other provider consulted; and

(4) in the case of a denial, notice of the appealing party's right to seek independent review of the denial and the procedure for obtaining that review, including the necessary forms.

If the appeal is denied, the *covered person's* health care provider may request, in writing, a review of the denial by a health care provider in the same or similar specialty as typically manages the condition, procedure, or treatment under review. This request must: (a) be made within ten working days of the denial of the appeal; and (b) set forth good cause for having a particular type of specialty provider review the case. The specialty review will be completed within 15 working days of receipt of the request.

Expedited Appeal

If the adverse determination involves emergency care, denial of care for a life-threatening condition, or denial of continued stay for a hospitalized *covered person,* the appealing party may call, write, or fax a request for an expedited appeal to the URA or to:

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 981573
El Paso, TX 79998-1573
Phone: (800) 541-7846
Fax: (509) 468-6123

A licensed *dentist* or licensed health care professional who typically manages the medical/dental condition under review and who did not previously review the case will review the appeal.

A decision will be made within a timeframe appropriate to the medical or dental immediacy of the condition, treatment or procedure under review but in no event later than one working day after receipt of all information required to make the decision.

The *covered person* and the *covered person's* health care provider will be notified by telephone or electronic transmission within one working day of making the decision. Written confirmation will also be sent to the *covered person* or a person acting on behalf of the *covered person.*

If the appeal is denied, the written notification will include:

(1) a statement of the specific reasons for the resolution;

(2) the clinical basis for such decision;

(3) the specialization of any *doctor* or other provider consulted; and

(4) in the case of a denial, notice of the appealing party's right to seek independent review of the denial and the procedure for obtaining that review, including the necessary forms.

External Appeals

A *covered person,* a person acting on the *covered person's* behalf, or the *covered person's doctor* or health care provider may request an external review of an adverse determination: (a) after the denial of a standard or expedited appeal; or (b) immediately in the case of a life-threatening condition. The request is made by completing the request form and executing the authorization to release medical information and sending them to the URA or to:

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 981573
El Paso, TX 79998-1573
Phone: (800) 541-7846
Fax: (509) 468-6123

Upon receipt of the request for external review, the Department will be notified of the request. The Department will assign an independent review organization(IRO) within one working day and will notify Guardian and the IRO of the assignment. The Department will notify the *covered person* or a person acting on behalf of the *covered person* and the *covered person's* health care provider within one working day of making the assignment.

Within three working days of receipt of the request for external review, the following information must be sent to the assigned IRO:

(1) any relevant medical records;

(2) any relevant portions of the utilization review *plan* used in making the decision;

(3) a copy of the written notice of the appeal's denial;

(4) any documentation and written information submitted by the appealing party in support of the appeal; and

(5) a list of the names, addresses, and phone numbers of each *doctor* or health care provider who has provided care to the *covered person* and who may have medical records relevant to the appeal.

The IRO should review the case and render a decision within the time frames shown below.

(1) If a life-threatening condition exists, the earlier of: (a) five working days of receipt of all information needed to complete the review; and (b) eight working days of receipt of the request for review.

(2) If a life-threatening condition does not exist, the earlier of: (a) 15 working days of receipt of all information needed to complete the review; and (b) 20 working days of receipt of the request for review.

The IRO should notify the *covered person* or person acting on behalf of the *covered person* and the *covered person's* health care provider of the decision.

This *plan* must cover charges for any covered services determined to be *medically necessary* or appropriate by the IRO. And, this *plan* will pay the cost of the external review.

CGP-3-DGY2K-APP-TX-10 B498.9160

Options A , B

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.

CGP-3-DGY2K-AT B498.0002

Options A , B

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.*

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.

CGP-3-DGY2K-PTR B498.0004

Options A , B

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.

CGP-3-DGY2K-OS B498.0005

Options A , B

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

Options A , B

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.

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.

CGP-3-DGY2K-LE B498.0232

Options A , B

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. Each *covered person* must have covered charges from these service groups which exceed the deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

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.*

CGP-3-DGY2K-BP-TX B498.0396

Option A

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

CGP-3-DGY2K-BP B498.0192

Option B

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $2,000.00.

CGP-3-DGY2K-BP B498.0192

Options A , B

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.

CGP-3-DG-ROLL-04-2.1 B498.2041

Option A

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.*

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* $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 provisions 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.*

CGP-3-DG-ROLL-04-2-TX B498.9147

Option B

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.*

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* $800.00
- *Reward* $400.00
- *Bank Maximum* $1,500.00

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 provisions 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.*

CGP-3-DG-ROLL-04-2-TX B498.9147

Options A , B

TMJ and Craniomandibular Disorders

We pay benefits for dental services for the necessary diagnostic and surgical treatment of temporomandibular (TMJ) and craniomandibular joint disorders in a covered person. We cover charges for such conditions as a result of: (1) an accident; (2) a trauma; (3) a congenital defect; (4) a developmental defect; or (5) a pathology.

We treat such services the same way we treat any other covered charges for Group III services.

Subject to the Group III deductible and all other terms of this plan, we pay benefits for such covered charges at a payment rate of 50%. And we won't pay for TMJ or craniomandibular treatment done in the first 24 months a late entrant is insured by this plan.

Under this plan's dental expense provisions, we don't cover any charges for the medical treatment of TMJ.

CGP-3-DGY2K-TMJ-07 B498.3590

Options A , B

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.*

CGP-3-DGY2K-FL B498.0073

Options A , B

Payment Rates

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

- Benefits for Group I Services 100%
- Benefits for Group II Services 80%
- Benefits for Group III Services 50%

CGP-3-DGY2K-PR-TX B498.0405

Options A , B

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.

CGP-3-DGY2K-END B498.0234

Options A , B

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Options A , B

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.*

- **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.

CGP-3-DGY2K-PP B498.0136

Options A , B

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.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis;* unless (1) it is at least 5 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.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing 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.
- 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.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*

CGP-3-DGY2K-EXCH B498.3361

Options A , B

List of Covered Dental Services

The services covered by this *plan* are named in this list. Each service on this list has been placed in one of three 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.

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.

CGP-3-DNTL-90-13 B490.0148

Options A , B

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.

CGP-3-DNTL-90-14 B498.4802

Options A , B

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.

CGP-3-DNTL-90-14 B498.0164

Options A , B

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 36 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

CGP-3-DNTL-90-14 B498.0165

Options A , B

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.

CGP-3-DNTL-90-14 B498.0166

Options A , B

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.

CGP-3-DNTL-90-15 B498.2780

Options A , B

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.

Options A , B

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
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

CGP-3-DNTL-90-15.0 B498.0201

Options A , B

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

Periodontal maintenance procedure - limited to a total of 1 prophylaxis or periodontal maintenance procedure(s) in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

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

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

CGP-3-DNTL-90-15.0 B498.0202

Options A , B

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

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

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

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

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

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

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

Guided tissue regeneration, resorbable barrier or nonresorbable barrier
Bone replacement grafts, when the tooth is present

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

CGP-3-DNTL-90-15.0 B498.0203

Options A , B

Non-Surgical Extractions

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

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

Surgical Extractions

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

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

Other Oral Surgical Procedures

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

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
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
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

CGP-3-DNTL-90-15.0 B498.1124

Options A , B

Other Services

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.*

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206

Group III - Major Dental Services
(Non-Orthodontic)

Major Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury,* and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or *injury.* Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

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

Inlays
Onlays, including inlay
Labial veneers
Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

Cast post and core in addition to a unit of crown or bridge, per tooth

Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth

Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch

Options A , B

Prosthodontic Services Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

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

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal

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

CGP-3-DNTL-90-16 B498.1132

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 follows 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.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-DGOPT-10 B531.0029

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

CERTIFICATE RIDER

This Rider amends this plan to provide additional services as described below.

ADDITIONAL NON-INSURANCE SERVICES

Guardian has arranged to make available, at the policyholder's option, selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and/or covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered persons will be provided the following service(s):

- Financial Planning Services - provides telephonic consultations with financial professionals and certified public accountants for financial planning issues such as credit counseling, debt and budget assistance, basic tax planning and retirement and college planning questions; provides a college tuition rewards program which helps earn scholarship rewards that can be redeemed within a private network of colleges. There is no additional charge above the premium to the covered person for these services.

Options A , B

When this Plan ends, access to the services ends for the Policyholder and for all persons covered under the Plan. When a Policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the Policyholder and for all persons covered under the Plan.

When a Covered Persons coverage under this Plan ends, access to the service ends for that person. When a Covered Person no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the Covered Person.

Guardian reserves the right to terminate, modify or replace any program at any time. We will give You 60 days advance notice of any service discontinuation.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B531.0789

CGP-3-A-VAP-AH-17-TX

COORDINATION OF BENEFITS

Important Notice This section applies to all group health benefits under this plan; except prescription drug coverage, 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.

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.

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. If the contract may not be renewed if the insured leaves the employer or organization, it is a group-type contract. If the contract allows for renewal regardless of continued employment or participation in an organization, it is a group-type contract only until the insured leaves the employer or organization.

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 and group subscriber contracts; (2) uninsured arrangements of group and group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group- type hospital indemnity benefits in excess of $100.00 per day; (6) medical benefits under group, group-type or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group- type hospital indemnity benefits of $100.00 or less per day; (ii) school accident type coverage; or (iii) Medicare, 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, except prescription drug coverage, if any, provided under this group plan.

CGP-3-R-COB-05 B555.0302

Options A , B

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.

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; and (c) the plan 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.

CGP-3-R-COB-05 B555.0303

Options A , B

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. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

If the primary plan is an HMO and an HMO member has elected to have health care services provided by a non-HMO provider, coordination of benefits will not apply between that plan and this plan.

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.

CGP-3-R-COB-05 B555.0304

Options A , B

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

Options A , B

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

CGP-3-GLOSS-90 B750.0664

Options A , B

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

CGP-3-GLOSS-90 B750.0665

Options A , B

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

CGP-3-GLOSS-90 B750.0666

Options A , B

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.

CGP-3-GLOSS-90 B750.0667

Options A , B

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

CGP-3-GLOSS-90 B750.0668

Options A , B

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

CGP-3-GLOSS-90 B750.0669

Options A , B

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.

CGP-3-GLOSS-90 B750.0670

Options A , B

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.*

CGP-3-GLOSS-90 B750.0671

Options A , B

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

CGP-3-GLOSS-90 B900.0003

Options A , B

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

CGP-3-GLOSS-90 B750.0015

Options A , B

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.*

CGP-3-GLOSS-90 B750.0672

Options A , B

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.

CGP-3-GLOSS-90 B750.0006

Options A , B

Employer means THE COUNTY OF GALVESTON .

CGP-3-GLOSS-90 B900.0051

Options A , B

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.

CGP-3-GLOSS-90 B900.0004

Options A , B

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 20 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

Options A , B

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.*

CGP-3-GLOSS-90 B900.0006

Options A , B

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.

CGP-3-GLOSS-90 B750.0673

Options A , B

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

CGP-3-GLOSS-90 B900.0008

Options A , B

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. This *plan* does not pay benefits for *orthodontic treatment.*

CGP-3-GLOSS-90 B750.0685

Options A , B

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.

CGP-3-GLOSS-90 B750.0676

Options A , B

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

CGP-3-GLOSS-90 B750.0677

Options A , B

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

CGP-3-GLOSS-90 B750.0679

Options A , B

Plan means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90 B750.0678

Options A , B

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.

CGP-3-GLOSS-90 B750.0681

Options A , B

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

CGP-3-GLOSS-90 B750.0682

Options A , B

Qualified Retirees are covered as outlined in your company's benefit provisions. Please see your Plan Administrator for details.

CGP-3-GLOSS-90 B750.0008

Options A , B

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

CGP-3-GLOSS-90 B750.0683

Options A , B

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

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.

B800.0094

The Guardian's Responsibilities

B800.0048

Options A , B

The dental expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

B800.0053

Options A , B

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

B800.0049

Group Health Benefits Claims Procedure

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 Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, 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.

B800.0076

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

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

B800.0007

Options A , B

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0051

Options A , B

Guardian is required to use or disclose your PHI :

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.

- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0052

Options A , B

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0053

Options A , B

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

EVIDENCE OF COVERAGE

Managed DentalGuard, Inc.
5850 Granite Parkway, Suite 800
Plano, Texas 75024
1-888-618-2016

The Group Dental Coverage described in this Evidence of Coverage is attached to the group Plan effective January 1, 2021. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Plan or under any other Plan providing similar or identical benefits issued to the Planholder by Us.

MANAGED DENTAL CARE PLAN

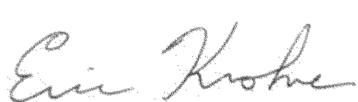
GROUP DENTAL COVERAGE

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP PLAN.

We certify that the Employee to whom this Evidence of Coverage is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of the Plan's eligibility and Effective Date requirements; (b) be listed in Our and/or the Planholder's records as a validly covered Employee under the Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee is not covered by any part of the Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Planholder's records.

Planholder: THE COUNTY OF GALVESTON
Group Plan Number: 00577847
Effective Date: January 1, 2021



Eric Krohne, President   Harris Oliner, Assistant Secretary

B426.0006

GC-DHMO-19-TX

A health maintenance organization (HMO) plan provides no benefits for services You receive from out-of-network physicians or providers, with specific exceptions as described in Your evidence of coverage and below.

You have the right to an adequate network of in-network physicians and providers (known as *network physicians and providers).*

If You believe that the network is in adequate, You may file a complaint with the Texas Department of Insurance at:
www.tdi.texas.gov/consumer/complfrm.html.

If Your HMO approves a referral for out-of-network services because no network physician or provider is available, or if You have received out-of-network emergency care, the HMO must, in most cases, resolve the out-of-network physician's or provider's bill so that You only have to pay any applicable in-network copayment, coinsurance, and deductible amounts.

You may obtain a current directory of network physicians and providers at the following website: www.GuardianAnytime.com or by calling Monday through Friday at 1-888-618-2016 from 8:30 a.m. to 6:30 p.m. Central Standard Time for assistance in finding available network physicians and providers. If you relied on materially inaccurate directory information, You may be entitled to have a claim by an out-of-network physician or provider paid as if it were from a network physician or provider, if You present a copy of the inaccurate directory information to the HMO, dated not more than 30 days before you received the service.

B426.0245

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GC-DHMO-19-TX

GENERAL PROVISIONS

Applicable Benefits

This Evidence of Coverage may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

B426.0010

Option C

Limitation of Authority

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

No change in this Evidence of Coverage will be valid unless evidenced by: (a) an endorsement or rider to this Evidence of Coverage signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of Us; or (b) an amendment to this Evidence of Coverage signed by the Planholder and by one of Our officers.

Only Our President, a Vice President or a Secretary has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Plan or Evidence of Coverage is to be issued;
- Waive or alter any contract, Plan or Evidence of Coverage, or any of Our requirements;
- Bind Us by any statement or promise relating to the Plan issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Plan or waive any of its provisions.

B426.0011

Option C

Incontestability

All statements made by the Employee on the written enrollment application are considered representations and not warranties. The statements are considered to be truthful and are made to the best of the Employee's knowledge and belief. A statement may not be used in a contest to void, cancel or non-renew an Employee's coverage or reduce benefits unless (a) it is in a written enrollment application signed by the Employee; and (b) a signed copy of the enrollment application is or has been furnished to the Employee or the Employee's personal representative.

A group Evidence of Coverage may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application. For small employer coverage, the misrepresentation shall be other than a misrepresentation related to health status.

We may increase the premium charge to an appropriate level if We determine that the Employee made a material misrepresentation of health status on the application. We must provide the Planholder 60 days prior written notice of any premium rate change.

In the event Your coverage is rescinded, We will refund premiums paid for the periods such coverage is void. The premium paid by You will be sent to Your last known address on file with the Planholer or Us.

B426.0014

Option C

Conformity With Statutes

If the provisions of this Evidence of Coverage do not conform to the requirements of any applicable Texas law or regulation, any such provision is changed to conform with the requirements of that law or regulation.

B426.0246

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Option C

Enrollment Procedures

In order for You to become a Employee under this Evidence of Coverage, (a) You must reside, live or work in the Plan's approved Service Area, and (b) the legal residence of any enrolled dependent must be:

(1) the same as Your residence;

(2) in the Service Area with the person having temporary or permanent conservatorship or guardianship of such dependent, including an adoptee or child who is the subject of a suit for adoption by You, where You have legal responsibility for the health care of such dependent; or

(3) anywhere in the United States for a child whose coverage under a Plan is required by a court ordered medical or dental support order.

You may enroll for dental coverage by:

- Completing and signing the appropriate enrollment form and any additional material required by Your Planholder.
- Returning the enrollment material to Your Planholder. Your Planholder will forward these materials to Us.

The enrollment materials require You to select a Primary Care Dentist (PCD) for each Member. After Your enrollment material has been received by Us, We will determine if a Member's selected PCD is available under Your Plan. If the PCD is available under the Plan, the selected Dentist will be assigned to the Member as his or her PCD. If a Member's selection is not available, an alternate Dentist will be assigned as the PCD. A Member need only contact his or her assigned PCD's office to obtain services.

We will issue You and Your dependents, either directly or through Your Planholder's representative, an ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

B426.0249

Option C

Open Enrollment Period

If You do not enroll yourself or Your eligible dependents for dental coverage under this Plan within 30 days of: a) the date of becoming eligible or b) the date of a Qualifying Event, You must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every 12 months after this Plan's Effective Date, or at time intervals mutually agreed upon by Your Planholder and Us.

Enrollment is for a minimum of 12 consecutive months while You are eligible. Voluntary termination from this Plan will only be permitted during the open enrollment period.

If after initial enrollment You, or one of Your dependents disenroll from the Plan before the open enrollment period, the Member may not re-enroll until the next open enrollment period which occurs after the Member has been without coverage for one full year.

B426.0021

Option C

Employee Eligibility

You are eligible for dental coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
  - The Planholder's place of business;
  - Some place where the Planholder's business requires You to travel; or
  - Any other place You and the Planholder have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for dental coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Planholder makes any payments to any kind of health and welfare benefit plan other than under this Evidence of Coverage.

B426.0026

Option C

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent children:

1. Who are under age 26;
   - Dependent child includes: (1) a stepchild who is dependent on You for most support and maintenance; (2) newborn child; (3) legally adopted child or foster child; (4) grandchild who is Your or Your Spouse's dependent for federal income tax purposes at the time the application for coverage of the grandchild is made; or (5) a child for whom You are court-appointed legal guardian, if the child (a) is part of Your household, and (b) is primarily dependent on You for support and maintenance. It also includes a child for whom You must provide medical or dental support under a court order, and any child who is the subject of a legal suit for adoption by You.
2. A mentally retarded or physically handicapped child who: (a) has reached the age limit of a dependent child: (b) is not capable of self-sustaining work: and (c) depends primarily on you for support and maintenance. You must furnish proof of such lack of capacity and dependence to Us within 31 days after the child reaches the age limit, and each year after that, if requested by Us. We cannot ask for this proof more than once a year.

Eligible dependent does not include anyone who is insured under this Plan as the Employee.

B426.0256

Option C

When Coverage Starts

Your Planholder will inform You of Your Effective Date under the dental Plan. Your coverage begins on the date:

- You and Your eligible dependent(s) are eligible for the dental Plan as stated in the Conditions Of Eligibility for Group Dental Coverage section; and
- You and Your eligible dependent(s) have enrolled in the dental Plan; and
- If Your dependent child is:

- A newborn then coverage begins on the date of birth. Coverage will automatically be provided for the initial 31 days from birth. For coverage to continue after the 31 day period, notice must be provided and any additional premium, if any, must be received by Us within the 31 day period.
- (a) A stepchild, or (b) a foster child then coverage begins when the child begins to reside in Your home.
- An adopted child then coverage begins on the date the child is subject to a legal suit for adoption. Coverage will automatically be provided for the initial 31 days. For coverage to continue after the 31 day period, notice must be provided and any additional premium, if any, must be received by Us within the 31 day period.
- A child who is the subject of a court ordered medical or dental support order is covered automatically for the first 31 days from the date of such an order. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of the date of the court or administrative order and pay any required premium to have coverage continue beyond the 31 day period.
- You must complete enrollment materials for a newborn, adopted, stepchild or foster child within 31 days of the child's coverage Effective Date.

- Required premiums have been paid.

If you not enroll by Your Effective Date, Your coverage will begin on:

- The first day of the month following the date enrollment materials are received by Us; or
- The first day of the month after the end of any waiting period Your Planholder may require; or
- The date you are eligible for the Plan based on the Planholder's eligibility rules as approved by Us.

B426.0261

Option C

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury of 90 days or less; or

- A day during a period of absence that is less than 7 days in duration;

And if:

- You were fully capable of performing Active Work for the Planholder for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Evidence of Coverage placed.

B426.0038

Option C

When Your Coverage Ends

Your coverage will end on the first of the following events:

- The date Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The date You stop being an eligible Employee under this Evidence of Coverage.
- The last day of the month in which You no longer reside, live or work in the Service Area.
- The date 30 days after We send written notice to You advising that coverage will end because You no longer reside, live or work in the Service Area. Such action must be taken by Us uniformly and without regard to any health-status related factors of an Employee. But coverage will not end for a child who is the subject of a court ordered medical or dental support order.
- The date the group Evidence of Coverage ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.
- The end of the 31-day grace period following the period for which Your Planholder last made the required premium payment.
- If You are required to pay all or part of the cost of coverage but fail to do so, the end of the period for which You made the last required payment.

- The end of the month during which Your Planholder receives written notice from You requesting termination of coverage for You and Your dependents, or on such later date as You may request by the notice.
- 15 days after We send written notification to the Employee advising that his or her coverage will end because the Employee has knowingly given false information in writing on his or her enrollment form, misused his or her ID card or other documents to obtain benefits under this Plan, or otherwise acted in an unlawful or fraudulent manner regarding services and benefits.
- The date 30 days after We send written notice to You advising that coverage will end because You failed to pay Patient Charges that are due.
- The date of Your misconduct, which is detrimental to the safety of Our operations and the delivery of services.
- The date You die.
- Upon You being no longer eligible for coverage, Texas law requires that Your Planholder provide You with coverage including the payment of premiums until the end of the month in which We are notified by Your Planholder You are no longer an eligible Employee.

B426.0285

Option C

When Your Dependent Coverage Ends

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Employee under this Evidence of Coverage.
- The date the group Evidence of Coverage ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- The date 30 days after We send written notice to a Member advising that coverage will end because the Member no longer resides, lives or works in the Service Area. Such action must be taken by Us uniformly and without regard to any health-status related factors of an Employee. But, coverage will not end for a child who is the subject of a court ordered medical or dental support order.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.

- For Your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.
- Upon You being no longer eligible for coverage, Texas law requires that Your Planholder provide You with coverage including the payment of premiums until the end of the month in which We are notified by Your Planholder You are no longer an eligible Employee.

B426.0307

Option C

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Evidence of Coverage carefully for details and discuss with Your Planholder or administrator.

B426.0051

Option C

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

B425.0071

Option C

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a Federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Plan would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Planholder for additional information.

B426.0055

Option C

COBRA Continuation Rights

If dental coverage for You or Your dependents ends, You or Your dependents may qualify for continuation of such coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Planholder or visit our website at www.GuardianAnytime.com.

B426.0057

Option C

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Planholder for information regarding such legally mandated leave of absence laws.

B426.0059

Option C

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Planholder's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B426.0060

Option C

Texas Continuation Rights

A Member whose dental coverage under the Plan ceases for any reason other than involuntary termination for cause and who has been continuously covered under the Plan for at least three consecutive months immediately prior to such termination, or under any prior Group Dental Plan providing similar coverage that the Plan replaces, may request dental coverage continuation.

Election of dental coverage continuation must be requested in writing by the Member to the Planholder no later than the 60th day after the later of the:

- date dental coverage would otherwise terminate; or
- date the Member is given notice by the Planholder of the right to elect to continue dental coverage.

The Member who elects to continue dental coverage must pay the Planholder no later than the 45th day after the initial election and monthly thereafter on the payment due date the contribution amount required by the Planholder, plus 2% of the coverage amount for the dental coverage under the Plan. Following the first payment made for initial coverage election, any other premium payment is considered timely if made on or before the 30th day after the date payment is due.

Group dental coverage continued may not terminate until the earliest of:

- the date the maximum continuation period provided by law would end, which is for any Member:
  - not eligible for continuation coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), nine months after the date the Member elects to continue the dental coverage; or
  - eligible for continuation coverage under COBRA, six additional months following any period of continuation coverage provided under COBRA;
- the date failure to make timely payments would terminate dental coverage;
- the date the dental coverage terminates in its entirety;
- the date the Member is or could be covered under Medicare;
- the date the Member is covered for similar benefits by another Dental Group Plan;
- the date the Member is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- the date similar benefits are provided or available to the Member under any state or federal law other than continuation coverage under COBRA.

Not later than the 30th day before the end of the continuation period described above that is applicable to the Member, the insurer must:

- notify the Member may be eligible for coverage under the Texas Health Insurance Risk Pool as provided by Chapter 1506; and
- provide to the Member the address for applying to that pool.

B426.0061

Texas Dependent Continuation Rights

This section applies only to the dental coverage provided by this Plan if coverage ends due to:

- the severance of a family relationship; or
- the retirement or death of the Employee.

A dependent of an Employee is eligible to continue dental coverage if:

- the dependent has been a member of the Plan for a period of at least one year; or
- is an infant under one year of age.

A dependent who exercises the option to continue dental coverage is not required to take and pass a physical examination as a condition to continuing coverage.

A Member covered under group continuation coverage is entitled to coverage that is identical in scope to the group dental coverage provided under this Plan. No additional exclusions that were not included in this Plan will be included in the group continuation coverage.

If the group Planholder replaces this Plan within the period described below, a Member covered under group continuation coverage may obtain group dental coverage benefits identical in scope to the group dental coverage under the replacement group plan.

The premium will not be more than the premium charged under this Plan for the dependent had the family relationship not been severed.

A Member covered under group continuation dental coverage is required to pay premiums for the group dental coverage directly to the Planholder. Premiums may be paid in monthly installments with an additional administrative fee of $5.00.

At the time this Plan is issued, the Planholder is required to give written notice of this continuation to each Member.

We require a Member to provide written notice to the Planholder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option. Written notice may be given by the Employee.

On receipt of notice, the group Planholder shall immediately give written notice of the continuation option to each affected Member.

On receipt of notice of the death or retirement of the Employee, the Planholder must immediately give written notice of the continuation option to each dependent of the Employee. The notice must state the amount of the premium to be charged and must be accompanied by any necessary enrollment forms.

Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the Employee, a Member must give written notice to the Planholder of the election to exercise the continuation option. Coverage under this Plan remains in effect during the period if the Plan's premiums are paid.

If a Member does not give written notice of the election to exercise the continuation option within the time period, the option expires.

Any period of previous dental coverage under this Plan must be used in full or partial satisfaction of any required probationary or waiting periods for Member coverage.

If this Plan provides to a Member continuation rights to cover the period between the time the Employee, retires and or is eligible for Medicare, the same continuation rights are available to the Employee's dependents.

The dental coverage of a Member who exercises the continuation option operates without interruption and may not be canceled or otherwise terminated until:

- the Member fails to make a premium payment within the time required to make the payment;
- the Member becomes eligible for substantially similar coverage under another Group Dental Plan or
- the third anniversary of (a) the severance of the family relationship or (b) the retirement or death of the Employee.

B426.0063

Option C

DENTAL BENEFITS

This Plan will cover many of the dental expenses incurred by You and those of Your dependents who are covered under this Plan. We interpret how the Plan is to be administered. What We cover and the terms of coverage are explained below.

B426.0068

Option C

How to Contact Us

Our customer service associates can assist You with benefit coverage questions, resolving problems, selecting or changing a Dentist. A customer service associate can be reached toll free Monday through Friday at 1-888-618-2016 from 8:30 a.m. to 6:30 p.m. Central Standard Time. An automated service is also provided after hours for eligibility verification.

B426.0065

Option C

Managed Dental Care

This Plan is designed to provide quality dental care while controlling the cost of such care. To do this, the Plan requires Members to seek dental care from Contracted Dentists that belong to the Network.

The Network is made up of Contracted Dentists in the Plan's approved Service Area. A Contracted Dentist is a Dentist that has a participation agreement in force with Us.

When a Member enrolls in this Plan, he or she will get information about current Contracted General Dentists. Each Member must be assigned to a Primary Care Dentist (PCD). The PCD will coordinate all of the Member's dental care covered by this Plan. After enrollment, a Member will receive an ID card. A Member must present this ID card or supply the Group Number and Member ID number when he or she goes to their PCD.

All dental services covered by this Plan must be coordinated by the PCD to whom the Member is assigned. What We cover is based on all the terms of this Plan. Please refer to the Schedule of Benefits for Group Dental Coverage information including Covered Dental Procedures and Patient Charges, Benefit Limitations and Exclusions.

B426.0066

Choice of Dentists

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

B425.0088

Option C

Changes in Dentist Participation

We may have to reassign a Member to a different Contracted Dentist if:

- The Member's Dentist is no longer a Contracted Dentist in the Network; or
- We take an administrative action which impacts the Dentist's participation in the Network.

If this becomes necessary, the Member will have the opportunity to request another Contracted Dentist.

If a Member has a dental service in progress at the time of the reassignment, We will subject to applicable law, either:

- Arrange for completion of the services by the original Dentist;
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service. If a Member has special circumstances as defined in section 843.362 of the Texas Insurance Code, a Member may be eligible for up to 90 days of continuing treatment from such Contracted Dentist after the Member's effective date of termination.
- The treating Dentist must:
  - Identify the special circumstance for which a Member needs services.
  - Request a Member be permitted to continue treatment under the Dentist's care, and
  - Agree not to seek payment from a Member for any amount for which a Member would not be responsible if the Dentist continued participation in the Network.

B426.0069

Option C

Refusal of Recommended Treatment

A Member may decide to refuse a course of treatment recommended by his or her PCD or Contracted Specialist. The Member can request and receive a second opinion by contacting a customer service associate. If the Member still refuses the recommended course of treatment, the PCD or Contracted Specialist may have no further responsibility to provide services for the condition involved and the Member may be required to select another PCD or Contracted Specialist.

B425.0090

Specialty Care Referrals

A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Contracted Specialist. We will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty care services are provided in accordance with the specialty care referral plan guidelines described below.

Specialty care referral guidelines, the screening criteria, are only used to approve requested treatment. The specialty care referral guidelines are objective, clinically valid and compatible with established and professionally recognized standards of practice. The specialty care referral guidelines are annually evaluated and updated as needed by the Peer Review Committee. Each request for referral will be reviewed on a case by case basis and special circumstances are considered when making Utilization Review decisions. Specialty care referral reviews are performed by qualified and trained clinical personnel; requests for additional information may be made by clinical personnel or by trained specialty care referral coordinators under the supervision of the clinical peer reviewer. Utilization review decisions involving Adverse Determinations are made by a clinical peer reviewer. At no time is a clinical peer reviewer's compensation based on negative determinations.

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

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a Contracted Specialist is required, the PCD must complete the specialty care referral request form. At this point, the following options are available:
  - The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to Us. We will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Contracted Specialist to schedule an appointment.
  - The PCD may determine that the direct referral to the Contracted Specialist fits the referral plan guidelines. If so, the PCD will complete the specialty care referral request form and provide this form to the Member and the Contracted Specialist. We will retrospectively review the direct referral upon receipt of the Contracted Specialist's claim, once the Contracted Specialist's procedures or services have been completed.

For preauthorization's, MDG has appropriate personnel reasonably available during 8 a.m. to 5 p.m. CST Monday through Friday on each day that is not a legal holiday. For preauthorization, MDG has a telephone system capable of receiving and/or recording incoming inquiries after 5 p.m. CST Monday through Friday and all day Saturday, Sunday and legal holidays and will acknowledge each of those calls no later than the next business day after the call is received.

For verifications and to provide determinations of previously requested verifications, MDG has appropriate personnel reasonably available during 8 a.m. to 5 p.m. CST Monday through Friday on each day that is not a legal holiday. MDG has a telephone system capable of receiving and/or recording incoming inquiries after 5 p.m. CST Monday through Friday and all day Saturday, Sunday and legal holidays and will respond to each of those calls as follows:

For requests relating to post-stabilization care or a life-threatening condition, within one hour of such request, or for requests received outside of the time period requiring appropriate personnel, within one hour after the beginning of the next time period requiring availability of appropriate personnel.

For requests relating to concurrent hospitalization, within 24 hours or within 24 hours after the beginning of the next time period requiring the availability of appropriate personnel.

For requests relating to non-hospitalization, within 3 calendar days from the date of receipt of the request for verification or within 3 calendar days after the beginning of the next time period requiring availability of appropriate personnel.

For requests relating to the renewal an existing preauthorization, such requests will be reviewed, and a determination will be made whether the service is preauthorized, if practicable, before the existing preauthorization expires.

For all other requests, within 3 calendar days from the date of receipt of the request for verification or within 3 calendar days after the beginning of the next time period requiring availability of appropriate personnel.

MDG will provide a mailed or faxed copy to the PCD of the verification or declination of services within three calendar days. If the PCD's request for a specialty care referral is denied (an Adverse Determination), the PCD and the Member will receive information on how to appeal the denial to an independent review organization. Refer to the Complaint and Appeal Procedures section for additional information.

If the service in question is a covered service and no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

The Plan's benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a covered service under the Plan, the Member will be responsible for the entire amount of the specialist's charge for that service.

A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

When specialty dental care is referred by the PCD, a Member will be referred to a Contracted Specialist for treatment. The Network includes Contracted Specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Plan's approved Service Area. If there is no Contracted Specialist in the Plan's approved Service Area, We will refer the Member to a Non-Contracted specialist Dentist of Our choice.

B426.0315

Option C

Out of Network Services

If a medically necessary covered dental procedure is not available through a Contracted Dentist or Contracted Specialist, We will, upon request from a Contracted Dentist or Contracted Specialist, allow referral to a Non-Contracted Dentist or specialist who will provide the covered services for the dental procedure where;

- A response to such request will be provided within 5 business days after receipt by Us of reasonably requested documentation for the covered dental procedure; and
- Any reimbursement for a Non-Contracted Dentist or specialist will be paid at the Non-Contracted Dentist's or Non-Contracted specialist's usual and customary rate or at an agreed rate.
- Before denying a request for out of Network services, We will provide for a review of the requested dental procedure by a specialist of the same or similar type of specialty as the Non-Contracted Dentist or specialist to whom the referral is requested.

B426.0316

Option C

Emergency Dental Services

Emergency Dental Services: This term means procedures administered in a Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.

The Network provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. The Member may seek covered Emergency Dental Services as defined above, without preauthorization, from any Dentist including a Non-Contracted Dentist. If a Member has an emergency, he or she should call his or her PCD, who will arrange for such care.

If a Member is unable to reach his or her PCD in an emergency, he or she should call MDG's Customer Service Department at 1-888-618-2016 for help with finding a Dentist. The hours are Monday through Friday from 8:30 a.m. to 6:30 p.m. Central time.

If the Member receives Emergency Dental Services from a Non-Contracted Dentist, We will pay the Non-Contracted Dentist at Our usual and customary rate or an agreed rate. We will reimburse the Member for the cost of the covered Emergency Dental Services, less the applicable Patient Charge(s).

Members must submit, to Us, the following information within 60 days or as soon as reasonably possible:

- A copy of the Dentist statement for the emergency services.
- Evidence of payment.
- A brief explanation of the emergency.

We will review each emergency services claim for necessity to ensure it meets Our guidelines and is not considered routine or definitive treatment.

B426.0317

Option C

DENTAL CLAIM REIMBURSEMENT

A claim for a covered Emergency Dental Services or authorized specialty care should be sent to Us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if a Member can show that it was not reasonably possible to submit the claim within that time. All claims must be received within one year of the treatment date. Claims may be submitted to: P.O. Box 2474, Spokane WA 99210-2474.

We will acknowledge receipt of a Member's claim in writing and initiate investigation within 15 business days. The Member will be requested to provide additional information, if required.

A claim submitted with all necessary information will be accepted or rejected within 15 business days of receipt. Notice of rejected claims will state the reasons for the rejection. In the event additional information is required and a determination cannot be made, a Member will receive notification within this 15-day period stating the reason for the delay.

A claim will be accepted or rejected within 45 days of that notice. Accepted claims will be paid no later than the 5th business day following notice of acceptance. If payment is subject to performance of an act by a Member, the claim will be paid no later than the 5th business day after the date the act is performed. For more information, please refer to Specialty Care Referrals and Emergency Dental Services.

B426.0318

Option C

Extended Dental Benefits

If a Member's coverage ends, We extend dental expense benefits for him or her under this Plan. We extend benefits for covered services other than orthodontic services only if the procedures are started before the Member's coverage ends and are completed within 90 days after the date his or her coverage ends.

- Inlays, onlays, crowns and bridges are started on the date the tooth or teeth are initially prepared.
- Dentures are started on the date the impressions are taken.
- Root canals are started on the date the pulp chamber is opened.

Coverage for orthodontic services ends upon the termination of the Member's coverage under this Plan.

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

We don't grant an extension if the Member voluntarily terminates his or her coverage. And what We pay is based on all the terms of this Plan.

B426.0075

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when a Member has dental coverage under more than one plan.

When a Member has dental coverage from more than one plan, this Plan coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated. Each plan is considered separately when coordinating payments.

Definitions

"Allowable expense" is a dental care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. 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 that is not covered by any plan covering the person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(2) 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 highest of the negotiated fees is not an allowable expense.

(3) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the Dentist has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Dentist's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

"Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a Non-Contracted Dentist. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the Member is responsible.

"Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

"Plan" means any of the following that provides dental expense benefits or services: (1) group or blanket insurance plans; (2) group Blue Cross plans, group Blue Shield plans or other service or prepayment plans on a group basis; (3) union welfare plans, employer plans, employee benefits plans, trusteed labor and management plans, or other plans for members of a group; (4) individual insurance contracts that pay or reimburse for the cost of dental care and (5) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other governmental program or coverage which We are not allowed to coordinate with by law. "Plan" also does not include blanket school accident-type coverage or disability income protection coverage.

"This Plan" means the part of this Plan subject to this Coordination of Benefits provision.

B426.0319

Option C

How This Provision Works: Order of Benefit Determination Rules

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its plan terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

If a Member is covered by more than one secondary plan, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that secondary plan.

If a plan has no coordination provision, it is primary, unless the provisions of both plans state that the complying plan is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

(1) **Nondependent or Dependent.** A plan that covers a Member as an employee or retiree pays first, the plan that covers a Member as a dependent pays second;

(2) **Dependent Child/Parents Not Separated or Divorced.** Except for dependent children of separated or divorced parents, the following governs which plan pays first when the Member is a dependent child of an employee:

(a) The plan that covers a dependent of an employee whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of an employee whose birthday falls later in the calendar year pays second. The employee's year of birth is ignored.

(b) If both parents have the same birthday, the benefits of the plan which covered a parent longer are determined before those of the other plan.

(3) **Dependent Child/Separated or Divorced Parents.** For a dependent child of separated or divorced parents, or parents not living together (whether or not they have ever been married), the following governs which plan pays first when the Member is a dependent of an employee:

(a) If a court order makes one parent financially responsible for the health care expenses or health care coverage of the dependent child, and the plan of that parent has actual knowledge of those terms, then that parent's plan pays first;

(b) If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the order of benefit determination rules outlined in the Dependent Child/Parents Not Separated or Divorced rule will apply.

(c) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the order of benefit determination Dependent Child/Parents Not Separated or Divorced rule will apply.

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) the plan of the parent with custody of the child;

(ii) the plan of the spouse of the parent with the custody of the child;

(iii) the plan of the parent not having custody of the child; and

(iv) the plan covering the Spouse of the noncustodial parent.

(4) **Dependent Child/Non-Parents.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits determination Nondependent or Dependent rule will apply.

(5) **Dependent Child with Spouse Coverage.** For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, the order of benefits determination Longer/Shorter Length of Coverage rule will apply. However, in the event that the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plan, the order of benefits is to be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's Spouse.

(6) **Active, Retired, or Laid-off Employee.** A plan that covers a Member as an active employee or as a dependent of such employee pays first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second. If the plan that we're coordinating with does not have a similar provision for such persons, then this rule will not apply. This rule does not apply if the Nondependent and Dependent rule can determine the order of benefits.

(7) **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, Member, subscriber, or retiree or covering the person as a dependent of an employee, Member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent and Dependent rule can determine the order of benefits.

(8) **Longer or Shorter Length of Coverage.** If the rules above don't determine which plan pays first, the plan that has covered the person for the longer time pays first. To determine the length of time a Member has been insured under a plan, two plans will be treated as one if the covered person was eligible under the second within 24 hours after the first plan ended. The Member's length of time covered under a plan is measured from his or her first date of coverage under the plan. If that date is not readily available, the date the Member first became a member of the group will be used. The start of a new plan does not include: a) a change in the amount or scope of a plan's benefits; b) a change in the entity which pays, provides or administers plan benefits; or c) a change from one type of plan to another.

(9) **Sharing Equally Between Plans.** If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

B426.0320

COORDINATION OF BENEFITS (COB)

This Coordination of Benefits (COB) provision applies when a Member has dental coverage under more than one plan.

When a Member has dental coverage from more than one plan, this Plan coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated. Each plan is considered separately when coordinating payments.

Definitions

"Allowable expense" is a dental care expense, including deductibles, coinsurance, and copayments, that is covered at least in part by any plan covering the person. 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 that is not covered by any plan covering the person is not an allowable expense. The following are examples of expenses that are not allowable expenses:

(1) If a person is covered by two or more plans that do not have negotiated fees and compute their benefit payments based on the usual and customary fees, allowed amounts, or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(2) 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 highest of the negotiated fees is not an allowable expense.

(3) If a person is covered by one plan that does not have negotiated fees and that calculates its benefits or services based on usual and customary fees, allowed amounts, or other similar reimbursement methodology, and another plan that provides its benefits or services based on negotiated fees, the primary plan's payment arrangement must be the allowable expense for all plans. However, if the Dentist has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Dentist's contract permits, the negotiated fee or payment must be the allowable expense used by the secondary plan to determine its benefits.

"Allowed amount" is the amount of a billed charge that a carrier determines to be covered for services provided by a Non-Contracted Dentist. The allowed amount includes both the carrier's payment and any applicable deductible, copayment, or coinsurance amounts for which the Member is responsible.

"Custodial parent" is the parent with the right to designate the primary residence of a child by a court order under the Texas Family Code or other applicable law, or in the absence of a court order, is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation.

"Plan" means any of the following that provides dental expense benefits or services: (1) group or blanket insurance plans; (2) group Blue Cross plans, group Blue Shield plans or other service or prepayment plans on a group basis; (3) union welfare plans, employer plans, employee benefits plans, trusteed labor and management plans, or other plans for members of a group; (4) individual insurance contracts that pay or reimburse for the cost of dental care and (5) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other governmental program or coverage which We are not allowed to coordinate with by law. "Plan" also does not include blanket school accident-type coverage or disability income protection coverage.

"This Plan" means the part of this Plan subject to this Coordination of Benefits provision.

B426.0321

Option C

How This Provision Works: Order of Benefit Determination Rules

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accord with its plan terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans equal 100 percent of the total allowable expense.

If a Member is covered by more than one secondary plan, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that secondary plan.

If a plan has no coordination provision, it is primary, unless the provisions of both plans state that the complying plan is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

(1) **Nondependent or Dependent.** A plan that covers a Member as an employee or retiree pays first, the plan that covers a Member as a dependent pays second;

(2) **Dependent Child/Parents Not Separated or Divorced.** Except for dependent children of separated or divorced parents, the following governs which plan pays first when the Member is a dependent child of an employee:

(a) The plan that covers a dependent of an employee whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of an employee whose birthday falls later in the calendar year pays second. The employee's year of birth is ignored.

(b) If both parents have the same birthday, the benefits of the plan which covered a parent longer are determined before those of the other plan.

(3) **Dependent Child/Separated or Divorced Parents.** For a dependent child of separated or divorced parents, or parents not living together (whether or not they have ever been married), the following governs which plan pays first when the Member is a dependent of an employee:

(a) If a court order makes one parent financially responsible for the health care expenses or health care coverage of the dependent child, and the plan of that parent has actual knowledge of those terms, then that parent's plan pays first;

(b) If a court decree states that the parents share joint custody, without stating that one of the parents is responsible for the health care expenses or health care coverage of the child, the order of benefit determination rules outlined in the Dependent Child/Parents Not Separated or Divorced rule will apply.

(c) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, the order of benefit determination Dependent Child/Parents Not Separated or Divorced rule will apply.

(d) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

(i) the plan of the parent with custody of the child;

(ii) the plan of the spouse of the parent with the custody of the child;

(iii) the plan of the parent not having custody of the child; and

(iv) the plan covering the Spouse of the noncustodial parent.

(4) **Dependent Child/Non-Parents.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits determination Nondependent or Dependent rule will apply.

(5) **Dependent Child with Spouse Coverage.** For a dependent child who has coverage under either or both parents' plans and has his or her own coverage as a dependent under a spouse's plan, the order of benefits determination Longer/Shorter Length of Coverage rule will apply. However, in the event that the dependent child's coverage under the Spouse's plan began on the same date as the dependent child's coverage under either or both parents' plan, the order of benefits is to be determined by applying the birthday rule to the dependent child's parent(s) and the dependent's Spouse.

(6) **Active, Retired, or Laid-off Employee.** A plan that covers a Member as an active employee or as a dependent of such employee pays first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second. If the plan that we're coordinating with does not have a similar provision for such persons, then this rule will not apply. This rule does not apply if the Nondependent and Dependent rule can determine the order of benefits.

(7) **COBRA or State Continuation Coverage.** If a person whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, Member, subscriber, or retiree or covering the person as a dependent of an employee, Member, subscriber, or retiree is the primary plan, and the COBRA, state, or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule does not apply. This rule does not apply if the Nondependent and Dependent rule can determine the order of benefits.

(8) **Longer or Shorter Length of Coverage.** If the rules above don't determine which plan pays first, the plan that has covered the person for the longer time pays first. To determine the length of time a Member has been insured under a plan, two plans will be treated as one if the covered person was eligible under the second within 24 hours after the first plan ended. The Member's length of time covered under a plan is measured from his or her first date of coverage under the plan. If that date is not readily available, the date the Member first became a member of the group will be used. The start of a new plan does not include: a) a change in the amount or scope of a plan's benefits; b) a change in the entity which pays, provides or administers plan benefits; or c) a change from one type of plan to another.

(9) **Sharing Equally Between Plans.** If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

B426.0322

COMPLAINT AND APPEAL PROCEDURES

Complaint Overview

Members are entitled: (a) to have any complaint reviewed by Us; and (b) to be provided with a resolution in a timely manner. We review each complaint in an objective, nonbiased manner and consider reaching a timely resolution a top priority.

The Member or Dentist may contact the customer services department to review a concern or file a complaint. The Quality of Care Liaison (QCL) may be contacted to file a complaint involving an adverse determination (utilization review), to file an appeal of an adverse determination, or to request a review by an independent review organization (IRO).

Complaint means any dissatisfaction expressed by a Member, the Member's designated representative or the Member's Dentist, by telephone or in writing, regarding Our operation, including but not limited to Our administration; procedures related to a review or appeal of an adverse determination; denial of access to a referral; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; and disenrollment decisions. This term does not include: (a) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Member; or (b) a Dentist's or Member's oral or written expression of dissatisfaction or disagreement with an adverse determination.

Adverse Determination means a determination by Us or a utilization review agent that a proposed or delivered dental service, by specialty care referral, which would otherwise be covered under the Member's Plan, is or was not a medically necessary service and may result in non-coverage of the dental procedure.

Medically necessary services, as related to covered services, means those dental services, requested by specialty care referral, which are: (1) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (2) consistent with nationally accepted standards of practice. Utilization review agent means an entity that conducts utilization review for Us.

Utilization review means a system for prospective, concurrent or retrospective review of the medically necessity and appropriateness of dental services being provided or proposed to be provided to a Member. The term does not include a review in response to an elective request for clarification of coverage.

Our customer services department and the QCL can be contacted by telephone at:

1-888-618-2016
or by mail at:

P.O. Box 2474, Spokane WA 99210-2474

The hours are from 8:30 a.m. to 6:30 p.m. Central Time. A Member may leave a message when calling after business hours, weekends, or holidays. At the time the Member is notified of an Adverse Determination, the forms required to file an appeal for an Independent Review are included with the notification letter. The Member has a right to request an Independent Review anytime after the first appeal to Us. If the Member wishes to contact the Texas Department of Insurance to discuss the Independent Review process, the telephone number is:

1-888-834-2476

Complaint Process Members make their concerns known by: (a) calling the customer services department, using the toll-free telephone number; or (b) directly contacting Us in writing.

Our customer services department document each telephone call and work with the Member to resolve their oral Complaint. The Member will be sent, within 5 business days from the date of receipt of the telephone call, an acknowledgement letter and a Complaint Form to complete if the Member desires additional review.

Upon receipt of a written Complaint or the Complaint Form, the QCL or QCL designee sends an acknowledgement letter to the Member within 5 business days. If a Complaint is made orally, an acknowledgement letter accompanied by a one-page complaint form that prominently and clearly states that the form must be returned to Us for prompt resolution of the Complaint.

We will review and resolve the written Complaint within 30 calendar days after the date of receipt.

The QCL or QCL designee is responsible for obtaining the necessary documentation; building a case file; and researching remaining aspects of the Complaint and any additional information. We may arrange a second opinion, if appropriate. Upon receipt of complete documentation, a resolution is determined by the QCL or QCL designee. Any issue involving a matter of quality of care will be reviewed with the Dental Director or the Director's designee and, if needed, with the Vice President of Network Management, legal counsel, and/or Complaint Committee and/or the Peer Review Committee.

The QCL or QCL designee is responsible for writing a resolution letter to the Member indicating the outcome of the review and the specialization of the dentists consulted, if applicable. Treatment plans and procedures; Contracted General Dentist and/or Contracted Specialist clinical findings and recommendations; plan guidelines, benefit information and contractual reasons for the resolution will be described, as appropriate. A copy of the Plan's appeal process will be enclosed with each resolution letter in the event the Member elects to have his or her Complaint re-evaluated. In addition, the method by which a Member can contact the Texas Department of Insurance for additional assistance will be noted in the resolution letter.

Complaints regarding Adverse Determination will be handled according to the established process outlined in the Utilization Review and Utilization Appeal Processes section (below).

The Texas Department of Insurance may review Complaint documentation during any Plan review.

We assert We are prohibited from retaliating against a group Planholder or a Member because the group Planholder or Member has filed a Complaint against Us or appealed a decision of Ours. We are prohibited from retaliating against a Dentist or Network provider because the Dentist or Network provider has, on behalf of a Member, reasonably filed a Complaint against Us or appealed Our decision.

The Complaint Committee and the Peer Review Committee

The Dental Director or the Director s designee and/or the QCL or QCL designee, may refer Complaints to the Complaint Committee or the Peer Review Committee for review and resolution.

The role of the Committees is to review Complaints, on a case by case basis, when the nature of the Complaint requires Committee participation and decision to reach resolution.

Once the matter has been resolved, the QCL or QCL designee will respond to the Member and will indicate in the file and the Quality Management Program (QMP) database that the matter is closed.

The Complaint Committee and Peer Review Committee will meet quarterly and as needed.

Minutes will be compiled for each Committee Meeting and will be maintained in Our office. Minutes of the meetings will be forwarded to the Quality Improvement Committee and Board of Directors.

B426.0323

Option C

Complaint Appeal Process

If the Member is not satisfied with the resolution, the Member may make a telephone or written request that an additional review be conducted by a Complaint Appeal Committee. The telephone appeal request will be logged in the Member's file and the Member will also be asked to send the request in writing. An acknowledgement letter will be sent to the Member within 5 business days from receipt of the written request for appeal.

This Committee will meet within 30 calendar days from receipt of the written request for appeal. The Committee is composed of an equal number of:

a. Representative(s) from Us;

b. Representative(s) selected from Contracted General Dentists;

c. Representative(s) selected from Contracted Specialist Dentists (if the complaint concerns specialty care); and

d. Representative(s) selected from plan Members who are not Our employees.

Members of the Complaint Appeal Committee will not have been previously involved in the Complaint resolution.

A representative from the Complaint Appeal Committee panel will be selected by the panel to preside over the Committee.

Within 5 business days from the date of receipt of the written request for an appeal, the Member will be sent written notice:

(a) acknowledging the date the appeal was received; and

(b) giving the date and location of the Committee meeting.

The Member will also be advised that:

(a) Member may appear in person before the Committee; or through a representative, if the Member is a minor or disabled before the Committee; or

(b) address a written appeal to the Committee; and

(c) may also bring any person to the Committee meeting. But, the participation of such person is subject to Our Complaint Appeal Committee guidelines.

The Member has the right to present: (a) written or oral information; and (b) alternative expert testimony and (c) to question the persons responsible for making the prior determination that resulted in the appeal.

The Committee will meet within the Member's county of residence or the county where the Member normally receives dental care or at another site agreed to by the Member, or address a written appeal to the Complaint appeal board.

We will complete the appeals process under this section within 30 calendar days after the date of the receipt of the request for appeal.

Not less than 5 business days prior to the Committee meeting, unless the complainant agrees otherwise, We will submit to the Member any and all documentation to be presented to the Committee, and the specialization of any dentist consulted during the investigation.

The Member will receive a written notice of resolution within 5 business days after the date of the Committee resolution. The resolution notice will include a written statement of:

(a) the specific medical determination;

(b) clinical basis; and

(c) the contractual criteria used to reach the final decision.

The notice will also prominently and clearly state the toll free telephone number and address of the Texas Department of Insurance.

The Member will provide for his/her own expenses relating to the Committee process. We will pay for its expenses relating to the Committee process. We will pay for the expenses of Our representative(s) and representative(s) selected from Contracted General Dentists and/or Contracted Specialists Dentists and the expenses of representatives selected from Our plan members. Following the decision of the Committee, We and the Member each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Contracted Dentist. Any use of arbitration by Us or a Member is voluntary and will be conducted in compliance with the Texas Civil Practice and Remedies Code, Chapter 171.

The Member may also contact the Texas Department of Insurance to file a complaint. The Department's address and toll-free telephone number are:

P. O. Box 149104
Austin, TX 78714-9104
Telephone: (800) 252-3439
Fax # 1 - (512) 490-1007
Web; www.tdi.texas.gov
E-mail: ConsumerProtection@tdi.texas.gov

Minutes will be compiled for each Committee Meeting and will be maintained in Our office. Minutes of the meetings will be forwarded to the Quality Improvement Committee and the Board of Directors.

B426.0082

Option C

Emergency Complaints Complaints involving an emergency will be concluded in accordance with the dental immediacy of the case not more than 24 hours from the receipt of the Complaint.

If the appeal of the emergency Complaint involves an Adverse Determination and involves a life-threatening condition, the Member or Member's Designee and Dentist may request the immediate assignment of an Independent Review Organization without filing an appeal. (See the Utilization Review and Utilization Appeal Processes which follows.)

Documentation Database With Our QMP database, it will be possible to track a Member's concern from the initial call through the final resolution of the issue. All steps in the resolution process may be documented in the database. Information will be accessible on groups, Members and dentists. The database will be accessed for information for the Quality Improvement Committee, the Complaint Committee and the Credentialing Committee. The database will provide aging reports and the reasons that Complaints are not resolved within 30 calendar days, if applicable.

We categorize complaints using the following:

- Quality of Care of Services
- Accessibility/Availability of Services
- Utilization Review or Management
- Complaint Procedures
- Physician and Provider Contracts
- Group Subscriber Contracts
- Individual Subscriber Contracts
- Marketing
- Claims Processing
- Miscellaneous

The three objectives of the logging system in the database are:

1. Accurate tracking of status of complaints;

2. Accountability of the different departments/personnel involved in the resolution process; and

3. Trending of the dental providers, Members, and groups for appropriate follow-up.

Documentation/Files Each written Complaint will be logged into the database by the QCL or QCL designee on the date it was received. The Member's data management system is documented to that a Complaint has been received and is being reviewed by the QCL or the QCL designee. A paper file is created and labeled with the Member's name and social security number. Any subsequent follow-up information is recorded in the file by the QCL or QCL designee. The file is to be kept in the Complaint File for 3 years. The file will include all correspondence about the issue, copies of records, radiographs and resolution. Only when a resolution is completed can the Complaint be closed and noted as closed in the Member's file and the database. Complaint files are available for regulatory review.

The Complaint Log will be reviewed quarterly by the Quality Improvement Committee.

Utilization Review and Utilization Appeal Processes

A copy of the Member Notification of the Utilization Review Appeals process that states an Independent Review can be requested after the first Appeal; unless the Member has a life-threatening condition or a Member who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the Plan. (See Expedited Appeals.)

Retrospective Utilization Review: The retrospective determination of the medical necessity and appropriateness, or the experimental or investigational nature of the dental service that has been provided to a Member will be communicated to the Dentist and the Member in writing within 30 calendar days from the date of receipt of the claim.

For a Member who is hospitalized at the time of the Adverse Determination: Oral notification of the Adverse Determination decision will be made no later than 1 business day from the receipt of all necessary information, followed up by the written notification within 3 business days from the date of receipt of all necessary information.

For a Member who is not hospitalized at the time of the Adverse Determination: Written notification of the Adverse Determination decision will be made no later than 3 business days from the receipt of all necessary information.

For a Member who is receiving post-stabilization care subsequent to emergency treatment at the time of the Adverse Determination: Oral notification of the Adverse Determination decision will be made no later than 1 hour from the receipt of all necessary information.

Adverse Determination Appeals: Written notification will be made no later than 30 calendar days from the date of receipt of the appeal.

Expedited Appeals: For a Member with a life-threatening condition or a Member who is denied the provision of prescription drugs or intravenous infusions for which the patient is receiving benefits under the health insurance Plan, the Member is entitled to immediately appeal to an Independent Review Organization (IRO) and is not required to comply with the internal appeal process.

The Member can contact the customer services department at:

1-888-618-2016
P.O. Box 2474
Spokane, WA 99210-2474

The plan hours are from 8:30 a.m. to 6:30 p.m. Central Time. The Service Area is in the Central Time Zone.

B426.0324

Option C

DEFINITIONS

This section defines certain terms appearing in Your Evidence of Coverage.

B426.0083

Option C

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Planholer, at:

- One of the Planholder's usual places of business;
- Some place where the Planholder's business requires You to travel; or
- Any other place You and the Planholder have agreed on for Your work.

B426.0084

Option C

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

B425.0103

Option C

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Us to participate in Our dental Network.

B425.0105

Option C

Contracted General Dentist: This term means a licensed dentist under contract with Us who is listed in Our directory of Contracted Dentists as a general practice dentist and who may be selected as a Primary Care Dentist by a Member.

B425.0106

Option C

Contracted Specialist: This term means a licensed Dentist under contract with Us as an endodontist, oral surgeon, orthodontist, pediatric dentist or periodontist.

B425.0107

Option C

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or Evidence of Coverage and covered by this Plan.

B426.0093

Option C

Effective Date: This term means the date the Plan goes into force and effect as stated on the cover page of the Evidence of Coverage, or any change to the Plan as requested by the Planholder and approved by Us and in force and effect as stated on cover page of the Evidence of Coverage.

B426.0094

Option C

Eligibility Date: This term means the earliest date You are eligible for coverage under this Evidence of Coverage as directed by the Planholder, and you have satisfied all requirements for coverage to begin, as required by this Evidence of Coverage.

B426.0095

Option C

Evidence of Coverage: This term means this Evidence of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Evidence of Coverage.

B426.0097

Option C

Full-time: This term means:

You are not a Part-time Employee as defined by Your Planholder and You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 20 hours per week) at:

- Your Planholder's place of business;
- Some place where the Planholder's business requires You to travel; or
- Any other place You and Your Planholder have agreed upon for the performance of Your job.

B426.0101

Option C

Member: This term means You, if You are covered by this Plan, and any of Your covered dependents.

B426.0102

Option C

Network: this term means Managed DentalGuard, Inc. network.

B426.0104

Option C

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Us to provide dental services to Employees in Our benefit Plan.

B426.0106

Option C

Patient Charge: This term means the amount the Member is responsible for. Patient Charge amounts are listed under the Covered Dental Procedures and Patient Charges section of the Schedule of Benefits.

B425.0123

Option C

Plan: This term means the Group Dental Coverage described in the Plan and this Evidence of Coverage.

B426.0108

Option C

Planholder: This term means a Planholder that is offering benefits to a Member under this Plan.

B426.0109

Option C

Primary Care Dentist (PCD): This term means a Contracted General Dentist selected by a Member who is responsible for providing or arranging for a Member's dental services.

B425.0126

Option C

Prior Carrier's Group Dental Plan: This term means the Planholder's Plan of group dental coverage which was in force immediately prior to this Plan. For a Plan to be considered a Prior Plan, the Plan with Us must start immediately after the prior coverage ends.

B426.0111

Option C

Qualifying Event: This term means a specific occurrence that changes a Member's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental Plan; divorce; death of Your Spouse; termination of another dental Plan; or any other event as required by state or federal law or in accordance with Your Planholder's rules.

B426.0113

Option C

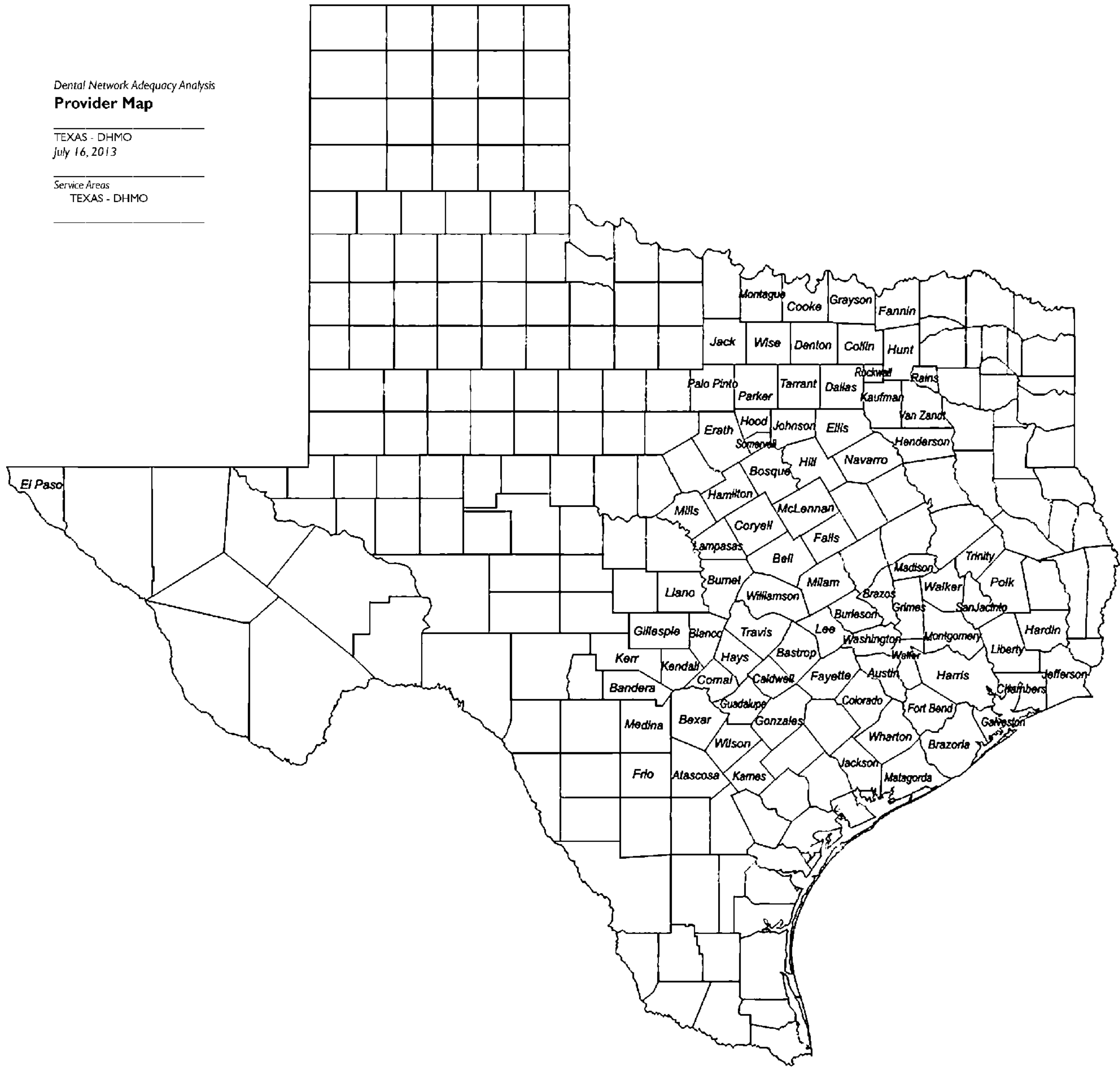
Service Area: This term means the geographic area in which We have arranged to provide for dental services for Members and includes:

Atascosa, Austin, Bandera, Bastrop, Bell, Bexar, Blanco, Bosque, Brazoria, Brazos, Burleson, Burnet, Caldwell, Chambers, Collin, Colorado, Comal, Cooke, Coryell, Dallas, Denton, El Paso, Ellis, Erath, Falls, Fannin, Fayette, Fort Bend, Frio, Galveston, Gillespie, Gonzales, Grayson, Grimes, Guadalupe, Hamilton, Hardin, Harris, Hays, Henderson, Hill, Hood Hunt, Jack, Jackson, Jefferson, Johnson, Kaufman, Karnes, Kendall, Kerr, Lampasas, Lee, Liberty, Llano, Madison, Matagorda, McLellan, Medina, Milam, Mills, Montague, Montgomery, Navarro, Palo Pinto, Parker, Polk, Rains, Rockwall, San Jacinto, Somervell, Tarrant. Travis, Trinity, Van Zandt, Walker, Waller, Washington, Wharton, Wilson, Williamson, and Wise counties.

Service Area Map located on the following page:

B426.0115

Option C



B426.0116

Option C

Spouse: This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B425.0132

Option C

We, Us, Our and MDG: These terms mean Managed DentalGuard, Inc.

You, Your or Yourself: These terms mean the covered Employee.

B426.0120

GLOSSARY

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

ABUTMENT: a tooth used to support a prosthesis.

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

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

AMALGAM: an alloy used in direct dental restorations.

ANALGESIA: loss of pain sensations without loss of consciousness.

ANESTHESIA: partial or total absence of sensation to stimuli.

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

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

APICOECTOMY: amputation of the apex of a tooth.

BICUSPID: a premolar tooth; a tooth with two cusps.

BILATERAL: occurring on, or pertaining to, both sides.

BIOPSY: process of removing tissue for histologic evaluation.

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

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

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

CARIES: commonly used term for tooth decay.

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

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

COMPOSITE: a tooth-colored dental restorative material.

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

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

CYST: pathological cavity, containing fluid or soft matter.

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

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

DENTURE: an artificial substitute for natural teeth and adjacent tissues.

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

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

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

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

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

EXCISION: surgical removal of bone or tissue.

EXOSTOSIS: overgrowth of bone.

EXTRAORAL: outside the oral cavity.

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

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

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

GINGIVECTOMY: the excision or removal of gingiva.

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

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

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

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

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

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

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

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

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

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

INTRAORAL: inside the mouth.

LABIAL: pertaining to or around the lip.

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

LINGUAL: pertaining to or around the tongue.

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MESIAL: toward the midline of the dental arch.

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

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

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

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

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

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

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

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

ORTHOGNATHIC: functional relationship of maxilla and mandible.

OVERDENTURE: prosthetic device that is supported by retained teeth roots.

PALLIATIVE: action that relieves pain but is not curative.

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

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

PEDIATRIC DENTIST: a dental specialist whose practice is limited to treatment of children.

PERIAPICAL: the area surrounding the end of the tooth root.

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

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

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

PERIRADICULAR: surrounding a portion of the root of the tooth.

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

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

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

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

PREMOLAR: see bicuspid.

PRIMARY DENTITION: the first set of teeth.

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

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

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

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

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

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

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

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

RADIOGRAPH: x-ray.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Option C

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Plano, Texas 75024
1-888-618-2016

GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Plan, as well as the Patient Charges, limitations, additional conditions and the exclusions. Please read the entire Evidence of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

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COVERED DENTAL PROCEDURES AND PATIENT CHARGES - N400

The procedures covered by the Plan are named in this list. If a procedure is not on this list, it is not covered. All procedures must be provided by the assigned Primary Care Dentist (PCD) or by referral to a Contracted Specialist.

A Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of the Plan, including the Benefit Limitations, Additional Conditions and Exclusions.

A Member may be charged a Patient Charge for a missed appointment or a cancelled appointment if the dental office is not given at least 24 hours notice of cancellation.

The Patient Charges listed are only valid for covered procedures that are: (1) started and completed under the Plan, and (2) rendered by Contracted Dentists.

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COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N400

CDT CODE **Current Dental Terminology (CDT) © American Dental Association (ADA)**

CDT CODE	COVERED DENTAL PROCEDURES	PATIENT CHARGE
	D0100-D0999 DIAGNOSTICS	
D0999	Office visit during regular hours, General Dentist only	$5
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0171	Re-evaluation - post-operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	Not Covered
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Not Covered
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	Not Covered
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Not Covered

D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination preparation and transmission of written report	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0
	D1000-D1999 PREVENTIVE	
D1110	Prophylaxis - adult, for the first two procedures in any 12 month period	$0
D1120	Prophylaxis - child, for the first two procedures in any 12 month period	$0
D1999	Prophylaxis - adult or child, for each additional procedure in the same 12 month period (maximum of 2 additional in the same 12 month period)	$35
M1110	Prophylaxis - One additional prophylaxis in any 12 month period will be covered at no charge for Members who: (a) are pregnant and in their 2nd or 3rd trimester; (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis.	$0
D1206	Topical application of fluoride varnish, for the first two procedures in any 12 month period	$0
D1208	Topical application of fluoride - excluding varnish, for the first two procedures in any 12 month period	$0
D2999	Topical fluoride each additional procedure in same 12 month period	$20
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth - molars	$6
D9999	Sealant - per tooth - non-molars	$35
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$6
D1353	Sealant repair - per tooth	$0
D1510	Space maintainer - fixed - unilateral	$60
D1515	Space maintainer - fixed - bilateral	$75
D1520	Space maintainer - removable - unilateral	$60
D1525	Space maintainer - removable - bilateral	$75
D1550	Re-cement or re-bond space maintainer	$8

Code	Procedure	Charge
D1555	Removal of fixed space maintainer	$20

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D2000-D2999 RESTORATIVE

Code	Procedure	Charge
D2140	Amalgam - one surface, primary or permanent, including polishing	$0
D2150	Amalgam - two surfaces, primary or permanent, including polishing	$0
D2160	Amalgam - three surfaces, primary or permanent, including polishing	$10
D2161	Amalgam - four or more surfaces, primary or permanent	$10
D2330	Resin-based composite - one surface, anterior, primary or permanent, including polishing	$15
D2331	Resin-based composite - two surfaces, anterior, primary or permanent, including polishing	$20
D2332	Resin-based composite - three surfaces, anterior, primary or permanent, including polishing	$25
D2335	Resin-based composite - four or more surfaces or involving incisal angle, (anterior), primary or permanent, including polishing	$40
D2390	Resin-based composite crown, anterior	$55
D2391	Resin-based composite - one surface, posterior, including polishing	$25
D2392	Resin-based composite - two surfaces, posterior, including polishing	$30
D2393	Resin-based composite - three surfaces, posterior, including polishing	$35
D2394	Resin-based composite - four or more surfaces, posterior, including polishing	$50
D2510	Inlay - metallic - one surface**	$200
D2520	Inlay - metallic - two surfaces **	$275
D2530	Inlay - metallic - three or more surfaces**	$325
D2542	Onlay - metallic - two surfaces **	$265
D2543	Onlay - metallic - three surfaces**	$275
D2544	Onlay - metallic - four or more surfaces**	$300
D2610	Inlay - porcelain/ceramic - one surface	$200
D2620	Inlay - porcelain/ceramic - two surfaces	$275
D2630	Inlay - porcelain/ceramic - three or more surfaces	$285
D2642	Onlay - porcelain/ceramic - two surfaces	$265
D2643	Onlay - porcelain/ceramic - three surfaces	$275
D2644	Onlay - porcelain/ceramic - four or more surfaces	$285
D2650	Inlay - resin-based composite - one surface	$201
D2651	Inlay - resin-based composite - two surfaces	$225
D2652	Inlay - resin-based composite - three or more surfaces	$250
D2662	Onlay - resin-based composite - two surfaces	$250
D2663	Onlay - resin-based composite - three surfaces	$300
D2664	Onlay - resin-based composite - four or more surfaces	$325
D2710	Crown - resin-based composite (indirect)	$200
D2712	Crown - 3/4 resin-based composite (indirect)	$200
D2720	Crown - resin with high noble**	$200
D2721	Crown - resin with predominantly base noble	$200
D2722	Crown - resin with noble metal	$200
D2740	Crown - porcelain/ceramic substrate	$285
D2750	Crown - porcelain fused to high noble metal**	$260

Code	Procedure	Charge
D2751	Crown - porcelain fused to predominantly base metal	$260
D2752	Crown - porcelain fused to noble metal	$260
D2780	Crown - 3/4 cast high noble metal**	$250
D2781	Crown - 3/4 cast predominantly base metal	$250
D2782	Crown - 3/4 cast noble metal	$250
D2783	Crown - 3/4 porcelain/ceramic	$250
D2790	Crown - full cast high noble metal**	$260
D2791	Crown - full cast predominantly base metal	$260
D2792	Crown - full cast noble metal	$260
D2794	Crown - titanium	$260
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$12
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$12
D2920	Re-cement or re-bond crown	$12
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$95
D2930	Prefabricated stainless steel crown - primary tooth	$60
D2931	Prefabricated stainless steel crown - permanent tooth	$60
D2932	Prefabricated resin crown	$90
D2933	Prefabricated stainless steel crown with resin window	$90
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$100
D2940	Protective restoration	$15
D2941	Interim therapeutic restoration - primary dentition	$10
D2949	Restorative foundation for an indirect restoration	$0
D2950	Core buildup, including any pins when required	$60
D2951	Pin retention - per tooth, in addition to restoration	$15
D2952	Post and core in addition to crown, indirectly fabricated	$95
D2953	Each additional indirectly fabricated post - same tooth	$30
D2954	Prefabricated post and core in addition to crown	$90
D2955	Post removal	$55
D2957	Each additional prefabricated post - same tooth	$20
D2960	Labial veneer (resin laminate) - chairside	$235
D2961	Labial veneer (resin laminate) - laboratory	$250
D2962	Labial veneer (porcelain laminate) - laboratory	$325
D2971	Additional procedures to construct new crown under existing partial denture framework	$125
D2980	Crown repair necessitated by restorative material failure	$50
D2981	Inlay repair necessitated by restorative material failure	$80
D2982	Onlay repair necessitated by restorative material failure	$85
D2983	Veneer repair necessitated by restorative material failure	$80
D2990	Resin infiltration of incipient smooth surface lesions	$25

D3000-D3999 ENDODONTICS

Code	Procedure	Charge
D3110	Pulp cap - direct (excluding final restoration)	$8
D3120	Pulp cap - indirect (excluding final restoration)	$8
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$35
D3221	Pulpal debridement, primary and permanent teeth	$35

Code	Procedure	Charge
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$35
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$41
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$95
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$135
D3330	Endodontic therapy, molar (excluding final restoration)	$170
D3331	Treatment of root canal obstruction; non-surgical access	$50
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$100
D3333	Internal root repair or perforation defects	$80
D3346	Retreatment of previous root canal therapy - anterior	$300
D3347	Retreatment of previous root canal therapy - bicuspid	$285
D3348	Retreatment of previous root canal therapy - molar	$360
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root restoration, etc.)	$35
D3352	Apexification/recalcification - interim medication replacement	$25
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root restoration, etc.)	$75
D3410	Apicoectomy - anterior	$180
D3421	Apicoectomy - bicuspid (first root)	$165
D3425	Apicoectomy - molar (first root)	$185
D3426	Apicoectomy - (each additional root)	$90
D3427	Periadicular surgery without apicoectomy	$145
D3430	Retrograde filling - per root	$40
D3450	Root amputation - per root	$85
D3920	Hemisection (including any root removal), not including root canal therapy	$90
D3950	Canal preparation and fitting of preformed dowel or post	$20

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D4000-D4999 PERIODONTICS

Code	Procedure	Charge
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$85
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$35
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$180
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$130
D4245	Apically positioned flap	$140
D4249	Clinical crown lengthening - hard tissue	$175
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$250

Code	Procedure	Charge
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$150
D4263	Bone replacement graft - first site in quadrant	$145
D4264	Bone replacement graft - each additional site in quadrant	$95
D4266	Guided tissue regeneration - resorbable barrier, per site	$130
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	$130
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$200
D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position.	$255
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$115
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$260
D4276	Combined connective tissue and double pedicle graft, per tooth	$240
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$230
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$145
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	$150
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	$160
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$40
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$25
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$30
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$45
D4910	Periodontal maintenance	$25
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$25
D4921	Gingival irrigation - per quadrant	$35
D4999	Periodontal maintenance, for each additional procedure in same 12 month period (maximum of 2 additional in the same 12 month period)	$60

D5000-D5899 PROSTHODONTICS - REMOVABLE

Code	Procedure	Charge
D5110	Complete denture - maxillary	$345
D5120	Complete denture - mandibular	$345
D5130	Immediate denture - maxillary	$345

Code	Procedure	Charge
D5140	Immediate denture - mandibular	$345
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$310
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$310
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$335
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$335
D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth	$326
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth	$326
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$352
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$352
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$430
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$430
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$130
D5410	Adjust complete denture - maxillary	$20
D5411	Adjust complete denture - mandibular	$20
D5421	Adjust partial denture - maxillary	$20
D5422	Adjust partial denture - mandibular	$20
D5510	Repair broken complete denture base	$45
D5520	Replace missing or broken teeth - complete denture (each tooth)	$35
D5610	Repair resin denture base	$45
D5620	Repair cast framework	$85
D5630	Repair or replace broken clasp - per tooth	$60
D5640	Replace broken teeth - per tooth	$32
D5650	Add tooth to existing partial denture	$45
D5660	Add clasp to existing partial denture - per tooth	$45
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$165
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$165
D5710	Rebase complete maxillary denture	$125
D5711	Rebase complete mandibular denture	$125
D5720	Rebase maxillary partial denture	$125
D5721	Rebase mandibular partial denture	$125
D5730	Reline complete maxillary denture (chairside)	$65
D5731	Reline complete mandibular denture (chairside)	$65
D5740	Reline maxillary partial denture (chairside)	$65
D5741	Reline mandibular partial denture (chairside)	$65
D5750	Reline complete maxillary denture (laboratory)	$120
D5751	Reline complete mandibular denture (laboratory)	$120
D5760	Reline maxillary partial denture (laboratory)	$120

D5761	Reline mandibular partial denture (laboratory)	$120
D5810	Interim complete denture (maxillary)	$293
D5811	Interim complete denture (mandibular)	$293
D5820	Interim partial denture (maxillary)	$135
D5821	Interim partial denture (mandibular)	$135
D5850	Tissue conditioning, maxillary	$32
D5851	Tissue conditioning, mandibular	$32

B425.0192

D6000-D6199 IMPLANT SERVICES

D6010	Surgical placement of implant body: endosteal implant	Not Covered
D6011	Second stage implant surgery	Not Covered
D6055	Connecting bar - implant supported or abutment supported	Not Covered
D6056	Prefabricated abutment - includes modification and placement	Not Covered
D6057	Custom fabricated abutment - includes placement	Not Covered
D6058	Abutment supported porcelain/ceramic crown	Not Covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)**	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)**	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)	Not Covered
D6064	Abutment supported cast metal crown (noble metal)	Not Covered
D6065	Implant supported porcelain/ceramic crown	Not Covered
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)**	Not Covered
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)**	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)**	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)**	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Not Covered
D6075	Implant supported retainer for ceramic FPD	Not Covered
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)**	Not Covered
D6077	Implant supported retainer for cast FPD (titanium, titanium alloy, or high noble metal)**	Not Covered
D6092	Re-cement or re-bond implant/abutment supported crown	Not Covered

Code	Procedure	Charge
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	Not Covered
D6094	Abutment supported crown (titanium)	Not Covered
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant, surfaces, including flap entry and closure	Not Covered
D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Not Covered
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	Not Covered
D6104	Bone graft at time of implant placement	Not Covered
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	Not Covered
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	Not Covered
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Not Covered
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	Not Covered
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	Not Covered
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	Not Covered
D6190	Radiographic/surgical implant index, by report	Not Covered
D6194	Abutment supported retainer crown for FPD (titanium)	Not Covered

B425.0176

D6200-D6999 PROSTHODONTICS - FIXED

Code	Procedure	Charge
D6205	Pontic - indirect resin based composite	$85
D6210	Pontic - cast high noble metal**	$260
D6211	Pontic - cast predominantly base metal	$260
D6212	Pontic - cast noble metal	$260
D6214	Pontic - titanium	$260
D6240	Pontic - porcelain fused to high noble metal**	$260
D6241	Pontic - porcelain fused to predominantly base metal	$260
D6242	Pontic - porcelain fused to noble metal	$260
D6245	Pontic - porcelain/ceramic	$285
D6250	Pontic - resin with high noble metal**	$200
D6251	Pontic - resin with predominantly base metal	$200
D6252	Pontic - resin with noble metal	$200
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$235
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$250
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$300
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$300

Code	Procedure	Charge
D6602	Retainer inlay - cast high noble metal, two surfaces**	$285
D6603	Retainer inlay - cast high noble metal, three or more surfaces**	$300
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$285
D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$300
D6606	Retainer inlay - cast noble metal, two surfaces	$285
D6607	Retainer inlay - cast noble metal, three or more surfaces	$300
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$275
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$375
D6610	Retainer onlay - cast high noble metal, two surfaces**	$275
D6611	Retainer onlay - cast high noble metal, three or more surfaces **	$300
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$275
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$300
D6614	Retainer onlay - cast noble metal, two surfaces	$275
D6615	Retainer onlay - cast noble metal, three or more surfaces	$300
D6624	Retainer inlay - titanium	$285
D6634	Retainer onlay - titanium	$300
D6710	Retainer crown - indirect resin based composite	$200
D6720	Retainer crown - resin with high noble metal **	$200
D6721	Retainer crown - resin with predominantly base metal	$200
D6722	Retainer crown - resin with noble metal	$200
D6740	Retainer crown - porcelain/ceramic	$285
D6750	Retainer crown - porcelain fused to high noble metal **	$260
D6751	Retainer crown - porcelain fused to predominantly base metal	$260
D6752	Retainer crown - porcelain fused to noble metal	$260
D6780	Retainer crown - 3/4 cast high noble metal **	$250
D6781	Retainer crown - 3/4 cast predominantly base metal	$250
D6782	Retainer crown - 3/4 cast noble metal	$250
D6783	Retainer crown - 3/4 porcelain/ceramic	$250
D6790	Retainer crown - full cast high noble metal **	$260
D6791	Retainer crown - full cast predominantly base metal	$260
D6792	Retainer crown - full cast noble metal	$260
D6794	Retainer crown - titanium	$260
D6930	Re-cement or re-bond fixed partial denture	$12
D6940	Stress breaker	$75
D6980	Fixed partial denture repair necessitated by restorative material failure	$70
D6999	Multiple crown and fixed partial denture retainers (bridge) treatment plan - per unit, six or more	$125

D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY

Code	Procedure	Charge
D7111	Extraction - coronal remnants - deciduous tooth	$8
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$10
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$35

Code	Procedure	Charge
D7220	Removal of impacted tooth - soft tissue	$60
D7230	Removal of impacted tooth - partially bony	$70
D7240	Removal of impacted tooth - completely bony	$90
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$100
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35
D7251	Coronectomy - intentional partial tooth removal	$75
D7260	Oroantral fistula closure	$120
D7261	Primary closure of a sinus perforation	$250
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$140
D7280	Surgical access of an unerupted tooth	$130
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$130
D7283	Placement of device to facilitate eruption of impacted tooth	$45
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$85
D7286	Incisional biopsy of oral tissue - soft	$65
D7287	Exfoliative cytological sample collection	$50
D7288	Brush biopsy - transepithelial sample collection	$65
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$35
D7310	Alveoloplasty, in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$60
D7311	Alveoloplasty, in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$35
D7320	Alveoloplasty, not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$75
D7321	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$60
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$85
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$175
D7471	Removal of lateral exostosis (maxilla or mandible)	$130
D7472	Removal of torus palatinus	$130
D7473	Removal of torus mandibularis	$130
D7485	Surgical reduction of osseous tuberosity	$130
D7510	Incision and drainage of abscess - intraoral soft tissue	$30
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$45
D7520	Incision and drainage of abscess - extraoral soft tissue	$50
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$55
D7953	Bone replacement graft for ridge preservation - per site	$130
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$100
D7963	Frenuloplasty	$160
D7970	Excision of hyperplastic tissue - per arch	$65
D7971	Excision of pericoronal gingiva	$50
D7972	Surgical reduction of fibrous tuberosity	$75

B425.0193

D8000-D8999 ORTHODONTICS

Code	Procedure	Charge
D8010	Limited orthodontic treatment of the primary dentition	$700
D8020	Limited orthodontic treatment of the transitional dentition	$700
D8030	Limited orthodontic treatment of the adolescent dentition	$700
D8040	Limited orthodontic treatment of the adult dentition	$700
D8050	Interceptive orthodontic treatment of the primary dentition	$900
D8060	Interceptive orthodontic treatment of the transitional dentition	$900
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,895
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,895
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,195
D8660	Pre-orthodontic treatment examination to monitor growth and development (includes treatment plan, records, evaluation and consultation)	$250
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$400
D8681	Removable orthodontic retainer adjustment	$0

D9000-D9999 ADJUNCTIVE GENERAL SERVICES B425.0178

Code	Procedure	Charge
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$15
D9120	Fixed partial denture sectioning	$15
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for deep sedation or general anesthesia	$55
D9223	Deep sedation/general anesthesia - each 15 minute increment	$98
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$40
D9248	Non-intravenous conscious sedation	$75
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$30
D9430	Office visit for observation (during regularly scheduled hours) no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$50
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$10
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$15
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$45
D9942	Repair and/or reline occlusal guard	$7
D9951	Occlusal adjustment - limited	$15
D9952	Occlusal adjustment - complete	$90
D9971	Odontoplasty, 1-2 teeth; includes removal of enamel projections	$14

D9972	External bleaching - per arch - performed in office	$165
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$99
D9986	Missed appointment	$25
D9987	Cancelled appointment	$25

** The Plan provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.

B426.0175

Option C

PLAN N400

B425.0139

Option C

BENEFIT LIMITATIONS

This section lists the dental benefits and procedures Members are allowed to obtain through the Plan when the procedures are necessary for their dental health, consistent with professionally recognized standards of practice, subject to the Benefit Limitations, Additional Conditions and Exclusions listed below.

B426.0182

Option C

General

Emergency Dental Services: The Member may seek covered Emergency Dental Services without preauthorization from any Dentist including a Non-Contracted Dentist. If a Member has an emergency, he or she should call his or her PCD, who will arrange for such care. If a Member is unable to reach his or her PCD in an emergency, he or she should call MDG's Customer Service Department at 1-888-618-2016 for help with finding a Dentist. The hours are Monday through Friday from 8:30 a.m. to 6:30 p.m. Central Time.

If the Member receives Emergency Dental Services from a Non-Contracted Dentist, We will pay the Non-Contracted Dentist at Our usual and customary rate or an agreed rate. We will reimburse the Member for the cost of the covered Emergency Dental Services, less the applicable Patient Charge(s).

B426.0325

Option C

Diagnostic

- Office visit Patient Charges that are the Member's responsibility after the group Plan has been in effect for three full years, will be paid to the PCD by Us.
- One intraoral complete series of radiographic images and one panoramic radiographic image: Limited to 1 each in 36 months.
- Bitewing radiographic images: Limited to 2 sets in 12 months.
- 2D oral/facial photographic image: Limited to 1 in 12 months.

- Caries susceptibility tests: Limited to 1 in 24 months.
- Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Limited to 1 in 24 months for persons age 40 or older.
- Accession of tissue is covered only when performed in conjunction with a tooth-related biopsy, when performed by a Contracted Dentist.

B426.0185

Option C

Preventive

- Prophylaxis (D1110 or D1120) or periodontal maintenance (D4910): Limited to 2 in 12 months. One of the covered periodontal maintenance may be performed by a periodontist Contracted Specialist if done within 3 to 6 months following completion of approved periodontal scaling and root planing or osseous surgery by a periodontist Contracted Specialist. Members are eligible to receive 2 additional prophylaxes or periodontal maintenance in the same 12 months at the Patient Charge of D1999 (for prophylaxes) or D4999 (for periodontal maintenance).

  One additional prophylaxis will be covered at no charge for Members in any 12 month period who: (a) are pregnant in their 2nd or 3rd trimester; or (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis. Verification of the condition must be provided by the Member with a doctor's note to the PCD.
- Fluoride treatment: Limited to 2 in 12 months. Members are eligible to receive 2 additional fluoride treatments in the same 12 months at the Patient Charge of D2999.
- Sealants or preventive resin restoration: Limited to permanent teeth that are free from occlusal restorations, up to age 16, once per tooth in 36 months.
- Sealant Repair: Limited to 1 per tooth in 12 months.

B425.0147

Option C

Crowns & Fixed Partial Dentures (Bridges)

- Crowns, fixed partial dentures (bridges), inlays, onlays & veneers: Covered when recommended by the PCD. The replacement of a crown, fixed partial denture (bridge), inlay, onlay or veneer is limited to once in 5 years based on the original placement date while covered under the Plan.
- Multiple crown and fixed partial denture (bridge) unit treatment plan: When a Member's treatment plan includes 6 or more covered units of crown and/or fixed partial denture (bridge) to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or fixed partial denture (bridge), plus an additional charge per unit (D6999), as shown in the Covered Dental Procedures and Patient Charges section.

- Porcelain crowns and/or porcelain fused to metal crowns: Covered on all permanent adult teeth when recommended by the PCD.
- The Plan provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.
- In the event a covered indirect restoration (inlays, onlays, crowns and fixed partial dentures - bridges) is recommended and the Member elects to have a porcelain/ceramic substrate indirect restoration made using a CAD/CAM machine in one appointment, in lieu of a laboratory processed porcelain/ceramic substrate indirect restoration (more than one appointment), the Member will be responsible for a fee of $500 in addition to the listed Patient Charge for such porcelain/ceramic substrate indirect restoration. Please note that the one-appointment porcelain/ceramic substrate indirect restoration may not be available at all Contracted General Dentist locations.

B426.0192

Option C

Endodontics

- Root amputation, per root: Limited to once per tooth.
- Hemisection: Limited to once per tooth.

B425.0149

Option C

Periodontics

- Gingival flap procedure or osseous surgery: Limited to 1 procedure per quadrant in 36 months.
- Tissue grafts: Limited to 1 procedure per tooth/site in 36 months.
- Periodontal scaling and root planing: Limited to once per quadrant in 12 months.
- Bone replacement grafts: Limited to once per site in 10 years when the tooth is present.
- Guided tissue regeneration: Limited to once per site in 10 years when the tooth is present.

B425.0151

Option C

Prosthodontics

- Reline and rebase of a complete or partial denture: Limited to once per denture in 12 months.
- The benefit for dentures includes all post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures includes follow-up care for 6 months but does not include rebasing or relining procedures or a complete new denture.
- Replacement of dentures: Covered when recommended by the PCD and only if the existing denture cannot be made satisfactory by reline, rebase or repair. The replacement of a denture is limited to once in 5 years based on the original placement date while covered under the Plan.
- Immediate dentures are not subject to the 5-year replacement limitation.

B426.0194

Option C

Oral and Maxillofacial Surgery

- Routine post-operative office visits and care: Included in the surgical procedure.

B425.0154

Option C

Orthodontics

- The Plan covers orthodontic procedures as listed under Covered Dental Procedures and Patient Charges. Coverage is limited to one course of comprehensive treatment per Member. Treatment must be preauthorized and be performed by an orthodontist Contracted Specialist.
- The listed Patient Charge for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. If treatment is necessary beyond 24 months, the Member will be responsible for each additional month of treatment, based upon the orthodontist Contracted Specialist’s contract.
- Orthodontic procedures are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Plan except as described under the Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
- If a Member’s coverage terminates after the fixed banding appliances are inserted, the Member is responsible for any additional charges incurred for the remaining orthodontic treatment. The orthodontist Contracted Specialist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the orthodontist Contracted Specialist for procedures after the termination date.
- Retention procedures are covered at the Patient Charge shown in the Covered Dental Procedures and Patient Charges section. They are covered only if following a course of comprehensive orthodontic treatment started and completed under the Plan.

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

- The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility.

- The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention procedures are covered only following a course of comprehensive orthodontic treatment covered under the Plan.

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

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

B426.0197

Option C

Adjunctive General Services

- Deep sedation/general anesthesia, IV sedation, nitrous oxide, non-intravenous conscious sedation: Limited to procedures provided by an oral surgeon Contracted Specialist. Not all oral surgeon Contracted Specialists offer these procedures. The Member is responsible for identifying and receiving procedures from an oral surgeon Contracted Specialist who is willing to provide deep sedation/general anesthesia, IV sedation, nitrous oxide or non-intravenous conscious sedation. The Member's Patient Charge is shown in the Covered Dental Procedures and Patient Charges section.

- Occlusal guard: Limited to 1 in 5 years. Covered only if performed by the PCD.

- Repair and/or reline of occlusal guard: Limited to 1 in 24 months if performed more than 24 months after initial fabrication and delivery.

- Occlusal adjustment - limited: Limited to a total of 2 visits, per lifetime.

B425.0156

Option C

ADDITIONAL CONDITIONS

B425.0157

Option C

Alternative Procedure Policy There may be a number of accepted methods of treating a specific dental condition. In all cases where there is more than one course of treatment (procedure) available, a full disclosure of all the treatment options must be given to the Member before treatment is initiated. This PCD-presented document should include a written treatment plan, as well as the cost of each treatment option, in order to minimize the potential for confusion over what the Member should pay, and to fully document the informed consent of the treatment recommended.

When a Member selects an Alternative Procedure over the procedure recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended procedure and the Alternative Procedure chosen by the Member. The Member will also have to pay the applicable Patient Charge for the recommended procedure.

If any of the Alternative Procedures that are selected by the Member are not covered under the Plan, the Member must pay the PCD's usual fee for the Alternative Procedure.

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

Members can request and receive a second opinion by contacting Our Member Services department in the event they have questions regarding the recommendations of the PCD or Contracted Specialist.

B426.0200

Option C

Exceptions to Alternative Procedure Policy When the Member selects a posterior composite restoration as an Alternative Procedure to a recommended amalgam restoration, the Alternative Procedure policy does not apply.

When the Member selects an extraction, the Alternative Procedure policy does not apply.

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

B425.0159

Option C

Second Opinion Consultation

A Member may wish to consult another Dentist for a second opinion regarding procedures recommended or performed by the Member's PCD or Contracted Specialist through a referral. To have a second opinion consultation covered by Us, the Member must call or write Our Member Services department for prior authorization. We only cover a second opinion consultation when the recommended procedures are covered under the Plan.

A Member Services associate will help identify a Contracted Specialist to perform the second opinion consultation. The second opinion consultation will include the applicable Patient Charge for code D9310.

The Plan's benefit for a second opinion consultation is limited to $50.00. If a Contracted Specialist is the consulting Dentist, the Member is responsible for the applicable Patient Charge for code D9310. If a Non-Contracted Dentist is the consulting Dentist, the Member must pay the applicable Patient Charge for code D9310 and any portion of the Dentist's fee over $50.00.

The Member Services associate will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting Dentist.

B426.0202

Option C

Third Opinion Consultation

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

B425.0161

Option C

Treatment in Progress-Takeover Benefit for Orthodontic Treatment Provision

This provision provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another Dental HMO plan with the current/original treating orthodontist, after the Plan becomes effective. A Member may be eligible for this provision if all of these conditions are met:

- The Member was covered by another dental HMO plan just prior to the Effective Date of the Plan and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior dental plan. This benefit applies to Members who are eligible for coverage on the Effective Date of the Plan and enroll for such coverage within 30 days. It does not apply to persons who become newly eligible for coverage after the Effective Date of the Plan.
- The Member has such orthodontic treatment in progress at the time the Plan becomes effective.

- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- A "Treatment in Progress - Takeover Benefit for Orthodontic Treatment" form, completed in its entirety by the treating orthodontist, is submitted to Us within 6 months of the Effective Date of the Plan.

The benefit amount will be calculated based on the prior dental HMO carrier's pro-rated remaining benefit balance; up to a maximum benefit of $1,200 per Member. The Member is responsible for the Dentist's original comprehensive treatment fee and Patient Charges under the original contract and financial agreement made between the Member and the Dentist. The Member is responsible for any increase in fee as a result of the takeover process. Additionally, the Plan will only cover up to a total of 24 months of comprehensive orthodontic treatment.

B426.0204

Option C

EXCLUSIONS

We will not pay benefits for:

- Treatment needed due to an on-the-job or job-related injury or a condition for which benefits are payable by Worker's Compensation, occupational disease law or similar laws, whether or not the Member claims his or her rights to such benefits.
- Dental procedures performed in a hospital, surgical center, or related hospital fees. This exclusion will not apply only if the Member's Dentist tells Us the Member:
  - Has a physical, mental, or medical condition that requires dental procedures be performed in a hospital or surgical center.
  - Is developmentally disabled.
  - Is in poor health and has a medical need for general anesthesia.
- Any treatment of congenital and/or developmental malformations. This does not apply for congenital defects for a newborn child which will be treated on the same basis as any other illness or injury for which dental treatment may apply. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatments or appliances requested, recommended or performed: (a) which in the opinion of the Contracted Specialist or Contracted General Dentist are not necessary for maintaining or improving the Member's dental health, or (b) which are solely for cosmetic purposes, except for bleaching.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or is considered by the American Dental Association (ADA) to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis, or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
- Any Member request for specialist procedures or treatment which can be routinely provided by the PCD, or by a specialist without a direct referral from the PCD or a pre-authorization by Us.

- Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits for such treatment.
- Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; (4) splint or stabilize teeth for periodontal reasons; or (5) improve cosmetic appearance, except for bleaching.
- Any procedure, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- Dental procedures, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's selected and assigned PCD, unless previous written authorization was provided by the Us.
- 2D cephalometric radiographic images except when performed as part of an orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Treatment which requires the procedures of a prosthodontist.
- Treatment or Procedures which requires the services of a pediatric dentist Contracted Specialist, after the Member's 9th (ninth) birthday.
- Consultations for non-covered procedures.
- Any procedure or treatment not specifically listed in the Covered Dental Procedures and Patient Charges section.
- Any covered procedure, regardless of specialty, that was started, but not completed, prior to the Member's eligibility to receive benefits under the Plan except as described under Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to, root canal therapy to facilitate overdentures.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under limited, interceptive or comprehensive orthodontic treatment or correct or control harmful habits.
- Any procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances lost or damaged.
- Accident injury. An accident injury is defined as damage to the hard and/or soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) functions will be covered at the amount as shown in the Covered Dental Procedures and Patient Charges section.

B426.0328

Option C

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

CERTIFICATE RIDER

This Rider amends this plan to provide additional services as described below.

ADDITIONAL NON-INSURANCE SERVICES

Guardian has arranged to make available, at the policyholder's option, selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and/or covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered Persons will be provided the following service(s):

- Financial Planning Services - provides telephonic consultations with financial professionals and certified public accountants for financial planning issues such as credit counseling, debt and budget assistance, basic tax planning and retirement and college planning questions; provides a college tuition rewards program which helps earn scholarship rewards that can be redeemed within a private network of colleges. There is no additional charge above the premium to the covered person for these services.

Option C

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the service ends for that person. When a covered person no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time. We will give You 60 days advance notice of any service discontinuation.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0137

Option C

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

Option C

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group Dental benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under 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.

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 (see Claims Procedures below).

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 Benefits 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 dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

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

If you have questions about this section, see your plan administrator.

Dental Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

Guardian is the Claims Fiduciary with discretionary authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has discretionary authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, 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 ERISA.

B405.0447

Option C

Definitions

"Adverse Benefit 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.

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.

Guardian will provide a Benefit Determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 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 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a Benefit Determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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.

Adverse Benefit Determination

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

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- 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;
- A description of the plan s review procedures and the time limits applicable to such procedures, including a statement of the claimant s right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either 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.

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. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) 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 Benefit Determination nor that person's subordinate;
- In deciding an appeal based upon a dental or 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 not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant s claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

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.

B405.0448

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Vision Insurance Coverage described in this Certificate is attached to the group Policy effective January 1, 2021. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Employer by Guardian.

GROUP VISION INSURANCE COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Certificate's eligibility and Effective Date requirements; (b) be listed in Our and/or the Employer's records as a validly covered Employee under the Policy; and (c) all required premium payments must have been made by or on behalf of the Employee subject to the Policy's grace period.

The Employee is not covered by any part of the Certificate for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Employer's records.

Employer: THE COUNTY OF GALVESTON

Group Policy Number: 00577847

Effective Date: January 1, 2021

The Guardian Life Insurance Company of America

Harris Oliner, Senior Vice President,
Corporate Secretary

Michael Prestileo,
Senior Vice President

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

B436.0044

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GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

Limitation of Authority

Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to any contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

Incontestability

This Certificate is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after his or her insurance has been in force for two years during his or her lifetime. In the absence of fraud, a statement may not be used to contest the validity of his or her insurance or to deny a claim for a loss incurred unless the statement is contained in a written instrument signed by the Covered Person.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

Grace Period

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Employees is not paid before the end of the grace period, the Policy and this Certificate ends with respect to all Employees at the end of the grace period. If the Policyholder gives Us advance written notice of an earlier termination date during the grace period, the Policy and this Certificate will end as of such earlier date.

If the Policy and this Certificate ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time this Policy and this Certificate was in force during the grace period.

B436.0045

CONDITIONS OF ELIGIBILITY FOR GROUP VISION INSURANCE COVERAGE

B435.0005

All Options

Employee Eligibility

You are eligible for vision coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee or Qualified Retiree; and
- Working at least the minimum required number of hours in Your eligible class at:
  - The Employer's place of business;
  - Some place where the Employer's business requires You to travel; or
  - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for vision coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Certificate.

Enrollment: If You must pay all or part of the cost of Employee coverage, You must enroll and agree to make required payments within 31 days of Your eligibility date. If You fail to do this, You cannot enroll until the plan's next vision open Enrollment Period. "Open Enrollment period" means an annual open enrollment period set up by the Employer and agreed to by Us.

This plan's vision open Enrollment Period occurs from November 1st to November 30th of each year.

Once You enroll in this plan, You cannot drop Your or Your dependent's vision coverage until this plan's next vision open Enrollment Period. Once You drop Your or Your dependent's vision coverage, You will not be permitted to enroll again until the next vision open Enrollment Period which starts after the date coverage is dropped.

If You initially waived vision coverage under this plan because You were covered under another group vision care plan, and You wish to enroll in this plan because Your coverage under the other plan ended, You may do so without waiting until the next vision open Enrollment Period. But, Your coverage under the other plan must have ended due to one of the events listed below:

- Termination of Your Spouse's employment.
- Loss of eligibility under Your Spouse's vision plan.
- Divorce.
- Death of Your Spouse.
- Termination of the other vision plan.

In that case, You must enroll in the vision coverage under this plan within 30 days of the date that any of the events listed above occurs.

B435.0971

All Options

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child from the moment of birth, natural child, an adopted child or any child to whom You or Your Spouse are a party to a suit to adopt the child, stepchild, a natural or adopted child of Your Spouse, a grandchild who is dependent on You for federal income tax purposes, a child for whom You are required by court to provide vision support or a child placed with You for foster care who is under age 26; and
  - A child who is incapable of self-support because of a physical or mental incapacity. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:
    - The condition started before he or she reached the age limit; and
    - The child remained continuously covered until he or she reached the age limit; and
    - You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Eligible dependent does not include anyone who is insured under the Policy as the Employee.

B436.0007

All Options

Eligibility Waiting Period

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Employer.

B400.0087

All Options

When Coverage Starts

Your Employer will inform You of Your Effective Date under the Group Vision Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Group Vision Policy as stated in the Conditions Of Eligibility for Group Vision Insurance section; and
- You and Your eligible dependents have enrolled in the Group Vision Policy; and
- Required premiums have been paid.

Newborn Children: Your newborn child is covered automatically from the moment of birth until the child is 31 days old. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of such birth and pay any required premium to have coverage continue beyond the 31 day period.

Adopted Children: Your adopted child is covered automatically for the first 31 days from the date that You or Your Spouse become a party to a suit in which You or Your Spouse seek to adopt the child. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of the date of the adoption and pay any required premium to have coverage continue beyond the 31 day period.

Children who are the Subjects of a Medical Support Order: A child who is the subject of a medical support order to provide vision coverage is covered automatically for the first 31 days from the date of such an order. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of the date of the court or administrative order and pay any required premium to have coverage continue beyond the 31 day period.

B436.0009

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;

and if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.0094

All Options

Family Status Change

You may request the addition of Vision Insurance Coverage if You have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request the addition of Vision Insurance Coverage for which You were not previously insured. You must provide proof of the Family Status Change and request the addition of Vision Insurance Coverage in writing within 31 days after the date of the Family Status Change as described above.

Refer to the When Coverage Starts section for information regarding when this coverage is effective.

B435.0981

All Options

When Your Coverage Ends

Your coverage will end on the first of the following events:

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for or by You, subject to the Policy's grace period.
- The date You die.

B436.0039

All Options

When Your Dependent Coverage Ends

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent, subject to the Policy's grace period.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B436.0015

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with Your Employer or administrator.

Continuation Rights

You may be eligible to continue Your group vision coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group vision coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group vision coverage under the Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

COBRA Continuation Rights

If vision insurance for You or Your dependents ends, You or Your dependents may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Employer or visit Our website at www.GuardianAnytime.com.

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B435.0038

All Options

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's vision coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B435.0040

All Options

VISION CLAIM PROVISIONS

You may visit any provider. After Davis Vision pays its portion of the covered charges, You are responsible for the rest. This includes any Deductible, Copayment, and amounts above any coverage maximum, as well as, any remaining charges up to the provider's total charge for services received.

Your reimbursement will be based on Davis Vision's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

B435.1186

All Options

Filing A Claim

If You have services performed by a Preferred Provider, Your claim will be submitted for You and the payment will be sent directly to Your Preferred Provider.

If You have services performed by a Non-Preferred Provider, You will need to submit Your own claim.

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate. We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to Notice and Proof of Loss.
- Consider and interpret the terms of this Certificate and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Certificate and applicable state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant, within a reasonable period of time, a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Notice: You must send Us written notice for which a claim is being made within 20 days of the service. We will not void or reduce Your claim if You cannot send Us notice of claim within the required time. In that case, You must send Us notice of claim as soon as reasonably possible. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

Claim Forms: We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, You will be considered to have complied with the requirements of the Certificate as to proof of loss and We will accept a written description and adequate proof of the service that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

Proof Of Loss: You must send written proof of loss to Our designated office within 90 days of the loss. We will not void or reduce Your claim if You cannot send Us proof of loss within the required time. In that case, You must send Us proof as soon as reasonably possible. However, under no circumstances will We pay benefits if written proof of loss is delayed for more than one year from the date that proof of loss is otherwise required, unless You are unable to provide proof of loss because You are not legally competent or You lack legal capacity.

Time Of Payment Of Benefits: We will pay Vision benefits no later than 60 days from the date We receive written proof of loss, subject to all the terms and conditions of this Policy.

Payment Of Benefits: Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living or to Your assignee. If You are not living, We have the right to pay all Vision benefits to one of the following:

Your

- Estate;
- Spouse;
- Parents;
- Children; or
- Brothers and sisters.

Upon written notice received by Us, benefits payable on behalf of a covered dependent child will be paid to the Texas Department of Human Services if:

- a Covered Person enrolled for dependent coverage is required to pay child support by a court order or court approved agreement; and
  - is a possessory conservator of the child under a court order issued in Texas; or
  - is not entitled to possession or access to the child;
- the Texas Department of Human Services is paying benefits on behalf of the child under Chapter 31 or 32, Human Resources Code; and
- We are notified through an attachment to the claim for benefits at the time the claim is first submitted to Us that the benefits must be paid directly to the Texas Department of Human Services.

Benefits payable on behalf of a covered dependent child will be paid to a person who is not covered under this plan if, at the time the claim is first submitted to Us, such person provides:

- Written notice that he or she is a possessory conservator of the child on whose behalf a claim is made; and
- A certified copy of a court order designating the person as possessory or managing conservator of the child.

All claims must be sent to Davis Vision within one year of the date services are completed or supplies are received. To obtain a claim form visit Our website at www.GuardianAnytime.com.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110-1525

Legal Actions: No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after 3 years from the date in which written proof of loss is required under the Policy to be filed.

Workers' Compensation: The Vision benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B436.0047

VISION EXPENSE BENEFITS

This coverage will pay many of a Covered Person's vision care expenses. We pay benefits for Covered Charges incurred by a Covered Person. What We pay and the terms for payment are explained below.

This Certificate includes the Schedule(s) of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

B435.0043

All Options

Davis Vision - This Plan's Vision Care Preferred Provider Organization

The Policy is designed to provide high quality vision care while controlling the cost of such care. To do this, the Policy encourages a Covered Person to seek vision care from vision care practitioners and vision care facilities that belong to Davis Vision, a vision care Preferred Provider Organization (PPO).

The vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. When a Covered Person is enrolled in the Policy, he or she will get an enrollment packet. The packet will: (1) explain how to obtain benefits; and (2) contain information about current vision care Preferred Providers. He or she will also receive information on how to obtain a list of Davis Vision Preferred Providers in his or her area.

A Covered Person may receive vision services from any Davis Vision Preferred Provider. If a Preferred Provider ends his or her relationship with Davis Vision for any reason, Davis Vision will be responsible for furnishing vision services to Covered Persons either through that provider or another Davis Vision Preferred Provider.

Use of the vision care PPO is voluntary. A Covered Person may receive vision care from any vision care provider he or she chooses. And he or she is free to change providers at any time. But, the Policy usually pays more in benefits for covered services furnished by a Preferred Provider. Conversely, it usually pays less for covered services not furnished by a vision care Preferred Provider.

What We pay is based on all of the terms of the Policy. Please read this Certificate carefully for specific benefit levels, Copayments, Deductibles, Payment Rates and Payment Limits.

A Covered Person may call Davis Vision should he or she have any questions about the vision coverage.

Davis Vision's Customer Service

800-999-5431

Obtaining Services from a Preferred Provider

When a Covered Person wishes to receive services from a Preferred Provider, he or she must contact the Preferred Provider before receiving the services. The Preferred Provider will contact Davis Vision to verify the Covered Person's coverage.

What We pay for charges for covered services is subject to all of the terms of this Certificate.

B435.0990

All Options

How This Plan Works

We pay benefits for the covered charges a Covered Person incurs as shown below. The services and supplies covered under this Certificate are explained in Covered Services and Supplies. What We pay is subject to all of the terms of this Certificate. Read the entire Certificate to find out what We limit or exclude.

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges Incurred by a Covered Person while he or she is covered by this Certificate. Charges in excess of any Payment Limits shown in this Certificate are not covered.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive authorization from Davis Vision. See Obtaining Services from a Preferred Provider.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to Davis Vision for claims payment. Please refer to Vision Claim Provisions in this Certificate.

If a Covered Person requires Emergency Care, as defined below, the Covered Person's Payment Rate will be the same for those emergency services provided by a Preferred Provider as those provided by a Non-Preferred Provider. What We pay is based on all of the other terms of this Certificate.

Emergency Care means services or supplies that are provided by a provider that are needed immediately because of an injury or sudden illness and the time required to reach a Preferred Provider can reasonably be expected to result in serious deterioration of, or risk of permanent damage to, the Covered Person's health. These services are considered to be Emergency Care as long as transfer of the Covered Person to a Preferred Provider is precluded because of risk to the Covered Person's health or because transfer would be unreasonable, given the distance involved in the transfer or the nature of the vision condition.

Copayments: A Covered Person must pay a Copayment each time he or she receives a vision examination. And, he or she must pay a Copayment each time he or she receives lenses or a frame or a complete pair of eyeglasses covered by this Certificate. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Certificate's Copayments are shown in the Schedule of Benefits.

Cash Deductibles: There are separate cash Deductibles for each covered service furnished by a Non-Preferred Provider. These cash Deductibles are shown in the Schedule of Benefits. The Covered person must have covered charges in excess of the cash Deductible before We pay benefits for the service or supply. The cash Deductible will be subtracted from the reimbursement to the member.

Payment Limits: Payment Limits, durational or monetary, are shown in Covered Services and Supplies. When a monetary Payment Limit is set for a pair of materials, the limit is halved if only one item is purchased.

Payment Rates: Once a Covered Person has paid any applicable Copayment or Deductible, We pay benefits for covered charges under this Certificate at the Payment Rate shown in the Schedule of Benefits. What We pay is subject to all of the terms of this Certificate.

B436.0053

All Options

Covered Services And Supplies

This section lists the types of charges We cover. But, what We pay is subject to all of the terms of this Certificate. Read the entire Certificate to find out what We limit or exclude.

B435.0048

All Options

Vision Examinations: We cover charges for comprehensive vision care examinations of visual functions and prescription of corrective eyewear. We only cover charges for one vision examination for each Covered Person in any one calendar year Benefit Period. The comprehensive vision care examination does not include a contact lens exam (evaluation and fitting).

If a Covered Person receives a vision examination from a Preferred Provider, We pay benefits in full for the covered charges for that examination.

If a Covered Person receives a vision examination from a Non-Preferred Provider, We pay benefits for the covered charges for that examination, up to $50.00.

B435.0049

All Options

Vision Materials We cover charges for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We cover charges for frames. And, We cover charges for prescription contact lenses. Benefit allowances provide no remaining balance for future use within the same Benefit Period.

In any one calendar year Benefit Period We cover charges for either glasses or contact lenses, but not both.

B435.1189

All Options

Standard Lenses: We cover charges for single vision, bifocal, trifocal or Lenticular Lenses. They must be glass or plastic lenses or for dependent children to age 19, for monocular individuals and Covered Persons with prescriptions of > +/- 6.00 diopters, Polycarbonate Lenses.

B435.1038

All Options

We only cover charges for one pair of Standard Lenses in any one calendar year Benefit Period.

B435.0187

All Options

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) $48.00 for each pair of single vision lenses; (2) $67.00 for each pair of bifocal lenses; (3) $86.00 for each pair of trifocal lenses; and (4) $126.00 for each pair of Lenticular Lenses.

B435.0057

All Options

We pay the following benefits in full when a Covered Person purchases lenses from a Preferred provider:

- Scratch Resistant Coating
- Oversize Lenses
- Fashion and Gradient Tinting of Plastic Lenses

B435.1040

All Options

Standard Frames: We cover charges for Standard Frames.

If a Covered Person uses a Preferred Provider, We cover charges up to a retail frame allowance of $150.00 for a non-collection frame. Most Preferred Providers discount any amount over the allowance by 20%. Discounts may not be available at all locations, check with Your Preferred Provider.

If a Preferred Provider offers Davis Vision's exclusive frame collection, We pay benefits for covered charges for any fashion or designer collection frame in full. And, We pay benefits for covered charges for any premier collection frame selected in full in excess of an additional $25.00 Copayment.

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for a set of Standard Frames to $48.00.

We only cover charges for one set of Standard Frames in any one calendar Year period.

B435.1076

All Options

Necessary Contact Lenses: We cover charges for necessary contact lenses but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover necessary contact lenses and charges for related professional services when a Preferred Provider obtains prior approval from Davis Vision but only if the lenses are needed: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for certain conditions of: Anisometropia; Aniseikonia; Keratoconus; Irregular Astigmatism; Corneal Disorders; Aphakia; Aniridia; or High Myopia.

And, We only cover charges for one pair of necessary contact lenses in any one calendar year Benefit Period.

If a Covered Person receives necessary contact lenses from a Preferred Provider, We pay 100% of the covered charges.

If a Covered Person receives necessary contact lenses from a Non-Preferred Provider, We limit what We pay for covered charges for such lenses to $210.00 in any one calendar year Benefit Period.

B435.1079

All Options

Elective Contact Lenses: We cover charges for elective contact lenses. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses.

If the Covered Person chooses elective contact lenses, We do not cover charges for Standard Lenses for one calendar year from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for non-Collection elective contact lenses to $150.00. Most Preferred Providers will discount any amount over the allowance by 15%. Discounts may not be available at all locations, check with Your Preferred Provider. Covered Persons must obtain all the elective contact lenses available within the Benefit Period at the same time. Any amounts remaining cannot be banked for future use.

If a Preferred Provider offers Davis Vision's elective contact lenses collection, We pay benefits for covered charges for any elective contact lenses selected from the collection in excess of the Copayment, if any. We cover two boxes of planned replacement or four boxes of disposable elective contact lenses. Contact lens fitting and evaluation (contact lens exam) is included at no additional cost only when collection contacts are purchased. The collection is not available at retail locations.

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for elective contact lenses to $105.00.

We cover charges for one set of elective contact lenses in any one calendar year Benefit Period.

Charges are covered up to the contact lens allowance. The allowance may be applied towards an elective contact lens Fitting and Evaluation at some provider locations.

B435.1086

All Options

Low Vision Benefits: We pay benefits for the covered charges at the Payment Rates shown in the Schedule of Benefits provided to a Covered Person who has severe visual problems which cannot be corrected with Standard Lenses.

Low Vision services are Low Vision Supplementary Testing and Low Vision Supplemental Care.

If a Covered Person receives Low Vision Supplementary Testing, We pay benefits for the covered charges for the testing up to $300.00 per test.

We cover no more than one Low Vision Supplementary Test(s) per Covered Person in any 5 year Period.

We cover services for Low Vision Aid devices up to $600.00 in any one calendar year Period with a lifetime maximum of $1,200.00.

We cover services for four follow up care visits in any 5 year period up to $100.00 per visit.

B435.1125

All Options

Exclusions

No benefits will be paid for services or materials connected with, or charges arising from:

- Orthoptics or vision training and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures.

- Any vision examination or corrective eyewear or safety eyewear required by an employer as a condition of employment unless specifically covered under this Certificate.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Services or materials provided by any other group benefit plan providing vision care.
- Plano Lenses (non-prescription lenses with less than a +/- .50 diopter power).
- Plano contact lenses to change eye color cosmetically or artistically painted contact lenses.
- Non-prescription sunglasses.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses, frames, glasses or contact lenses furnished under this Certificate which are lost or broken, except at normal intervals when services are otherwise available.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses, such as polishing or cleaning or modifications to contact lenses.
- Corneal refractive therapy (CRT) or orthokeratology (using contact lenses to change the shape of the cornea to reduce myopia).
- A frame that costs more than this Certificate allowance.
- Unused allowance amounts cannot be banked for future use. The allowance must be used during the same office visit.
- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.
- Blended Lenses
- Progressive Multi-Focal Lenses
- Polycarbonate Lenses for adults
- High Index Lenses
- Anti-Reflective Coating of the lens or lenses
- Polarized/Laminated Lenses
- Ultraviolet Coating of Lenses
- Transition Lenses
- Photochromic Lenses
- Mirror and Ski Coating

- Edge Treatment

Charges not covered due to these exclusions are not considered charges for covered vision services and cannot be used to satisfy this Certificate's Copayments or Deductibles, if any.

B435.1128

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B435.0102

All Options

Aniridia: This term means the absence of the iris in the eye, occurring congenitally or as a result of trauma or surgery.

B435.1042

All Options

Aniseikonia: This term means a condition that results from an excessive difference in the prescription between the eyes. This causes a difference in image size perceived between the eyes from unequal magnification, and can manifest with symptoms of headache, dizziness, disorientation, and excessive eye strain.

B435.1043

All Options

Anisometropia: This term means a condition in which two eyes have unequal refractive power. Each eye can be nearsighted (myopia), farsighted (hyperopia), or a combination of both, which is called antimetropia. Generally a difference in power of two diopters or more is the accepted threshold to label the condition anisometropia.

B435.1044

All Options

Anti-Reflective Coating: This term means a clear lens coating that limits light reflection by allowing the maximum amount of light to pass through the lens.

B435.0105

All Options

Aphakia: This term means the absence of the lens of an eye, occurring congenitally or as a result of trauma or surgery without implantation of an intraocular lens.

B435.0106

All Options

Benefit Period: This term means the time period beginning when a covered service is received and extending for the period shown in this Certificate, during which benefits for the covered service are available to a Covered Person.

B040.0846

Blended Lenses: This term means bifocals which do not have a visible dividing line.

B040.0847

Certificate: This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B435.0108

Copayment: This term means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a Covered Person to a Preferred Provider at the time covered services are received.

B435.0109

All Options

Corneal Disorders: This term means any condition (other than Keratoconus) of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes.

B435.0110

All Options

Covered Person: This term means You, if You are covered by the Policy, and any of Your covered dependents.

B435.0185

All Options

Deductible: This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B435.0111

All Options

Edge Treatment: This term means a cosmetic service to make the sides of a cut lens look clear rather than a milky white.

B435.0112

All Options

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B435.0113

All Options

Eligibility Date: This term means the earliest date You are eligible for coverage under this Certificate as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

B435.0114

All Options

Employee: This term means the member of the group determined to be eligible by the Employer.

B435.0115

All Options

Employer: This term means the entity that purchased the Policy.

B435.0116

All Options

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B040.0856

All Options

Fashion and Gradient Tinting of Plastic Lenses: This term means lenses which have an additional substance added to produce constant tint or coating that is darker at the top of the lens, fading to lighter at the bottom.

B435.1045

All Options

Fitting and Evaluation: This term means an examination for the proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.

B435.0117

All Options

Full-time: This term means:

You are not a Part-Time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employer in Your Eligible class (but not less than 20 hours per week), at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B435.0146

All Options

High Index Lenses: This term means material that is used to create thinner lenses than normal plastic. The material does not contain the impact-resistant qualities of polycarbonate.

B435.0120

All Options

High Myopia: Refractive error greater than plus or minus 10.00 diopters of correction; best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with contact lenses.

B435.0121

All Options

Incurred, or Incurred Date: These terms mean: (1) the placing of an order for lenses, frames or contact lenses; or (2) the date on which such an order was placed.

B040.0860

All Options

Irregular Astigmatism: This term means greater than or equal to 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90 degrees, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles.

B435.0123

All Options

Keratoconus: This term means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area. Diagnosis confirmed by keratometric readings, or corneal topography best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses.

B435.0124

All Options

Lenticular Lenses: This term means mean high-powered lenses with the desired prescription power found only in the central portion. The outer portion has a front surface with a changing radius of curvature.

B040.0862

All Options

Low Vision: This term means a partial loss of vision; a loss of acuity or sharpness or a loss of side/peripheral vision; and that the Covered Person's most favorable corrected visual acuity is 20/70 or worse in one or both eyes.

B435.1046

All Options

Low Vision Supplemental Care: This term means subsequent Low Vision therapy, when visually necessary or appropriate.

B435.1047

All Options

Low Vision Supplementary Testing: This term means a Low Vision analysis and diagnosis. The analysis and diagnosis includes: (a) a comprehensive examination of visual functions; and (b) the prescription of corrective eyewear or vision aids, when required.

B435.1048

All Options

Mirror and Ski Coating: This term means a thin deposit of appropriate material to the front surface of a lens, causing a portion of the light striking the lens to reflect directly from the front surface.

B435.0125

All Options

Non-Preferred Provider: This term means any optometrist, therapeutic optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that is not under contract, directly or indirectly, with Davis as a Preferred Provider.

B436.0065

All Options

Orthoptics: This term means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

B040.0865

All Options

Oversize Lenses: This term means larger than a standard lens blank, to accommodate prescriptions.

B040.0866

All Options

Payment Limit: This term means the maximum amount this Certificate pays for covered services and supplies during a specified Benefit Period.

B435.0128

All Options

Payment Rate: This term means the percentage rate that this Certificate pays for covered services and supplies.

B435.0129

All Options

Photochromic Lenses: This term means lenses which change color with the intensity of sunlight.

B040.0870

All Options

Plano Lenses: This term means lenses which have no refractive power (lenses with less than a greater than or equal to .38 diopter power).

B435.0130

All Options

Polarized/Laminated Lenses: This term means lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

B435.0131

All Options

Policy: This term means the group Vision Insurance Coverage described in the Policy and this Certificate.

B435.0132

All Options

Polycarbonate Lenses: This term means the highest impact-resistant lens material available. Its high-index properties result in lenses 20-25% thinner than regular plastic. This material is often used for safety and children's eyewear as well as for sports and cosmetic purposes.

B435.0133

All Options

Preferred Provider: This term means an optometrist, therapeutic optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has entered into a contract, directly, or indirectly with Davis to provide vision care services and or Vision Materials to Covered Persons.

B436.0066

All Options

Progressive Multi-Focal Lenses: This term means lenses that have no line, but progresses from distance, to intermediate, to near vision.

B435.0135

All Options

Qualified Retiree: This term means Qualified Retirees are covered as outlined in Your company's benefit provisions. Please see your Plan Administrator for details.

B040.0875

All Options

Scratch Resistant Coating: This term means a coating applied to spectacle lenses to increase the scratch resistance of the lens surface.

B435.0136

All Options

Spouse: This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B435.0137

All Options

Standard Frames: This term means frames valued up to the limit published by Davis Vision which is given to Preferred Providers.

B435.1051

All Options

Standard Lenses: This term means regular glass or plastic lenses.

B435.0139

All Options

Tinted Lenses: This term means lenses which have an additional substance added to produce constant tint.

B040.0878

All Options

Transition Lenses: This term means plastic lenses that turn dark when exposed to the ultraviolet rays of the sun.

B435.0140

All Options

Ultraviolet Coating (UV): This term means a coating that blocks ultraviolet rays.

B435.0141

All Options

Usual And Customary: This term means that the charge for the covered vision condition: (1) is the provider's standard charge for the service furnished; and (2) is not more than the usual charge made by most other providers with similar training and experience in the same geographic area. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

B040.0879

All Options

Vision Materials: This term means (1) Elective Contact Lenses; or (2) Standard Lenses, Standard Frames or a complete pair of eyeglasses (lenses and frames).

B435.0142

All Options

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

B435.0143

All Options

You, Your or Your: These terms mean the covered Employee.

B435.0144

All Options

VISION INSURANCE COVERAGE SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date; or 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B435.1131

All Options

Initial Election You may choose to be covered under one of the plans of vision expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B435.0151

All Options

Group Enrollment Period A group enrollment period is held each year from November 1st to November 30th. During this period, You may choose to enroll for vision insurance coverage under the Policy. In that case, coverage is scheduled to start on the date determined by Your Employer that next follows the date You enroll.

B435.0155

All Options

PPO Copayments	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$10.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$10.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Payment Rates	For Covered Charges	100%

B435.1137

All Options

Changes in Coverage Amounts If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective until the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change.

B435.1139

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

CERTIFICATE RIDER

This Rider amends this plan to provide additional services as described below.

ADDITIONAL NON-INSURANCE SERVICES

Guardian has arranged to make available, at the policyholder's option, selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and/or covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered Persons will be provided the following service(s):

- Financial Planning Services - provides telephonic consultations with financial professionals and certified public accountants for financial planning issues such as credit counseling, debt and budget assistance, basic tax planning and retirement and college planning questions; provides a college tuition rewards program which helps earn scholarship rewards that can be redeemed within a private network of colleges. There is no additional charge above the premium to the covered person for these services.

All Options

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the service ends for that person. When a covered person no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time. We will give You 60 days advance notice of any service discontinuation.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0137

CGP-3-A-VAP-AH-17-TX

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

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