YOUR
GROUP INSURANCE
PLAN

GUEST SERVICES, INC.
CLASS 0001
DENTAL

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.

EVIDENCE OF COVERAGE

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

Plan No.	Evidence No.	Effective Date
Issued To		

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

B110.0051

TABLE OF CONTENTS

IMPORTANT NOTICE
An Important Notice About Continuation Rights 2

YOUR CONTINUATION RIGHTS
Federal Continuation Rights 3
Uniformed Services Continuation Rights 7

ELIGIBILITY FOR DENTAL COVERAGE
Employee Coverage 8
Your Right To Continue Group Coverage During
A Family Leave Of Absence 9
Dependent Coverage 11

DENTAL HIGHLIGHTS 15

DENTAL EXPENSE INSURANCE
Covered Charges 17

COMPLAINT & APPEAL PROCESS
Internal Appeal Procedures 21
Alternate Treatment 26
Proof Of Claim 26
Pre-Treatment Review 27
Benefits From Other Sources 28
The Benefit Provision - Qualifying For Benefits 28
Rollover of Benefit Year Payment Limit for
Group I, II and III Non-Orthodontic Services 29
After This Insurance Ends 33
Special Limitations 34
Exclusions 36
List of Covered Dental Services 40
Group I - Preventive Dental Services 40
Group II - Basic Dental Services 42
Group III - Major Dental Services 47
Group IV - Orthodontic Services 49

CERTIFICATE AMENDMENT 51

COORDINATION OF BENEFITS
Definitions 53
Order Of Benefit Determination 55
Effect On The Benefits Of This Plan 57
Right To Receive And Release Needed Information 57
Facility Of Payment 57
Right Of Recovery 58

SUBROGATION AND RIGHT OF RECOVERY 59

GLOSSARY 62

STATEMENT OF ERISA RIGHTS
The Guardian's Responsibilities 70
Group Health Benefits Claims Procedure 71
Termination of This Group Plan 75

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE 76

IMPORTANT NOTICE

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

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

As used in this booklet, the terms:

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

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

B115.0126

An Important Notice About Continuation Rights

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

B235.0109

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

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) a covered actived 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 you are a qualified continuee and your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

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.

B235.0568

All Options

If You Die While Covered

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

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

B235.0181

All Options

Your Employer's Responsibilities

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

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

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

Election of Continuation

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

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

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

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

Grace in Payment

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

When Continuation Ends

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

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

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

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

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

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

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

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

B235.0190

All Options

Uniformed Services Continuation Rights

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

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

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

B235.0194

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

All Options

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, you will not be able to enroll for coverage until the next enrollment period.

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,* you can enroll immediately for 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. If you do not enroll within this 30 day period, you will have to wait until the next enrollment period.

B489.0640

All Options

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.

B489.0067

All Options

When Your Coverage Ends

If you are an active *full-time employee,* your coverage ends on the date your active *full-time* service ends for any reason, other than disability. Such reasons include death, retirement (except for *qualified retirees),* layoff, leave of absence and the end of employment.

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

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

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

B489.0089

All Options

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.

B449.0727

All Options

Dependent Coverage

B200.0271

All Options

Eligible Dependents For Dependent Dental Benefits

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

B489.0506

All Options

Adopted Children And Step-Children

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

Dependents Not Eligible

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

B489.0509

All Options

Handicapped Children

You may have a child who is: (i) incapable of self-sustaining employment by reason of intellectual disability or physical handicap; and (ii) chiefly dependent on you for support and maintenance. 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 is unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance. But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year. The child's coverage ends when yours does.

B449.0860

All Options

Special Enrollment Conditions

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, you can immediately enroll them in the dental coverage under this plan, 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. If you do not enroll your eligible dependents within this 30 day period, you will have to wait until the next enrollment period.

In addition, you can immediately enroll your spouse or eligible dependent children for dental coverage 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. If you do not enroll your eligible dependents within this 30 day period, you will have to wait until the next enrollment period.

B489.0642

All Options

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 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, you will be unable to enroll your initial dependents until the next enrollment period.

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, you will be unable to enroll your newly acquired dependent until the next enrollment period.

B489.0658

All Options

Exception

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

B200.0692

All Options

Newborn Children

We cover your newborn child for dependent benefits, from the moment of birth if: (a) you are already covered for dependent child coverage when the child is born; or (b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, you will not be able to enroll your child until the next enrollment period.

B489.0664

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of an employee's dependents when his or her employee coverage ends. But, if an employee dies while insured, we'll automatically continue dependent benefits for those of his or her dependents who were insured when he or she 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 an employee's dependents when the employee stops 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 an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she 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 at 12:01 a.m. on the date the child attains this coverage's age limit.

B489.0813

All Options

It happens to a spouse on the date a marriage ends in legal divorce or annulment.

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

B489.1152

All Options

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

B497.0075

Option A

- **Payment Rates:**

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

B497.0086

Option B

- **Payment Rates:**

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

B497.0087

Option B

- **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.

B497.1431

Option A

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

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

- **Lifetime Payment Limit for Orthodontic Treatment**

  For Group IV Services . . . . . Up to $2,500.00

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

B497.1432

All Options

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.

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.

B497.2420

All Options

DENTAL EXPENSE INSURANCE

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

B498.0007

Option A

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.

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. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

B498.0069

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.

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.

B498.0070

COMPLAINT & APPEAL PROCESS

Definitions As used in this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B490.0248

All Options

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

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

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

B490.0249

All Options

Internal Appeal Procedures

Complaint Process

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

In Writing: Center for Quality Health Care Services and Consumer Protection
Virginia Department of Health
9960 Mayland Drive, Suite 401
Henrico, Virginia 23233

Telephone: 804-367-2104 (Richmond Metro Area)
800-955-1819

Fax: 804-367-2149

E-mail: mchip@vdh.state.va.us

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

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

For Dental Claims

Guardian
Group Quality Assurance-WRO
P.O. Box 981573
El Paso, TX 79998-1573

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

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

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

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

Appeals of Adverse Determinations

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

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

For Dental Claims

Guardian
Group Quality Assurance-WRO
P.O. Box 981573
El Paso, TX 79998-1573

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

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

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

b) board certified; and

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

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

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

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

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

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

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

B497.2505

All Options

Urgent Care Appeals of Adverse Determinations

When the *treating health care provider* believes that an *adverse determination* or adverse reconsideration warrants an immediate *appeal,* the *treating health care provider* shall have the opportunity to *appeal* on an urgent care basis.

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

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

For Dental Claims

Guardian
Group Quality Assurance-WRO
P.O. Box 981573
El Paso, TX 79998-1573

Phone: 1-800-541-7846
Fax: 1-509-468-6399

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

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

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

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

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

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

B497.2460

All Options

Consumer Assistance

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

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

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

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

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

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

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

The address, telephone number, or E-mail address shown below should be used in order to obtain assistance with any questions regarding an *appeal* or *complaint* concerning the health care services provided which have not been satisfactorily addressed by the *utilization review entity.*

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

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

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

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

B490.0253

All Options

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.

B498.0002

Option A

Pre-Treatment Review

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

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

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

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

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

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

B498.0003

Option 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.*

Pre-Treatment Review (Cont.)

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

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

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

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

B498.0004

All Options

Benefits From Other Sources

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

B498.0005

All Options

The Benefit Provision - Qualifying For Benefits

B498.0072

All Options

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.*

B498.0187

Option A

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

B498.0192

Option B

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

B498.0192

All Options

The Benefit Provision - Qualifying For Benefits

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

B498.2041

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.

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

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

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

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

- *Rollover Threshold* $800.00
- *Reward* (if all benefits are for services provided by a *preferred provider)* $600.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider)* $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.

Definitions of terms used in this provision:

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

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

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

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

B498.9065

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

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

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

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

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

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

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

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

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

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

Definitions of terms used in this provision:

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

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

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

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

B498.9065

Option A

How We Pay Benefits For Group IV Orthodontic Services

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

We pay for Group IV covered charges at the applicable *payment rate.*

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

We make the initial payment when the *active orthodontic appliance* is first placed. *We* make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan. We* limit what *we* pay for orthodontic services to the lifetime payment of $2,500.00. What *we* pay is based on all of the terms of this *plan.*

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan. We* limit what *we* pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan.* Based on the original treatment *plan, we* determine the portion of charges incurred by the *covered person* prior to being covered by this *plan,* and deduct them from the total charges. What *we* pay is based on the remaining charges. *We* limit what *we* consider of the proposed treatment *plan* to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits *we* pay for *orthodontic treatment* won't be charged against a *covered person's benefit year* payment limits that apply to all other services.

B498.0059

All Options

Non-Orthodontic Family Deductible Limit

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

B498.0073

Option 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%

B498.0082

Option A

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%
- Benefits for Group IV Services 50%

B498.0084

Option A

After This Insurance Ends

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

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

B498.0233

Option 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.

B498.0234

All Options

Special Limitations

B498.0138

All Options

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan. We* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

B498.0133

Option A

If This Plan Replaces The Prior Plan

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

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

B498.0129

Option 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.*

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

B498.0131

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.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- 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 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.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*
- Harmful habit appliances.

B498.2111-R

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- 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 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.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.
- Harmful habit appliances.

B498.2113-R

Option A

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 four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

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

B490.0048

Option 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.

B490.0148

All Options

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to 2 prophylaxes in a calendar year, to a maximum of 4 total prophylaxes and periodontal maintenance procedures in a calendar year. 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 2 treatment(s) in a calendar year.

Office Visits, Evaluations and Examination

Office visits, oral evaluations, examinations, emergency or problem focused oral evaluations or limited problem focused re-evaluations - limited to a total of two in a calendar year.

Screening of a patient - limited to twice in a calendar year.

Assessment of a patient - limited to twice in a calendar year.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment. Limited to twice per calendar year.

B498.9032-R

All Options

Space Maintainers

Space Maintainers - limited to *covered persons* under age 14 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

B498.0164-R

All Options

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.

Diagnostic Services

Pulp vitality tests

Collection of microorganisms for culture and sensitivity

Collection and preparation of genetic sample material for laboratory analysis and report - one per lifetime.

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, twice in a calendar year.

Intraoral periapical or occlusal films - single films

B498.8740-R

All Options

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.

Preventive resin restoration in a moderate to high caries risk patient - permanent tooth - limited to unrestored permanent molar teeth. Limited to one treatment, per tooth, in any 36 consecutive month period.

Interim caries arresting medicament application - limited to permanent bicuspid and molar teeth, once per tooth in 36 months.

B498.0166-R

All Options

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

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.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits.

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 24 months have passed since the previous restoration was placed. Also see the "Major Restorative Services" section.

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

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

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

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

B498.2780-R

All Options

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

B498.1122

All Options

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

B498.0201

All Options

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 four periodontal maintenance procedures in a calendar year, to a maximum of 4 total prophylaxes and periodontal maintenance procedures in a calendar year. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services")

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.

B498.2855-R

All Options

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 36 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

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

B498.0203-R

All Options

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

B498.1124

All Options

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.

Desensitizing medicaments where periodontal treatment, such as scaling and root planing or periodontal surgery has been performed.

B498.0206-R

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, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment
- Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

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

Other Implant services

Bone replacement graft for ridge preservation and sinus augmentation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, in any 60 consecutive month period.
Radiographic/surgical implant index - limited to once per arch in any 24 month period
Repair implant supported prosthesis
Repair implant abutment
Implant removal
Cleaning and inspection of removable complete and partial dentures - limited to one in any 6 consecutive month period.

B498.1129-R

All Options

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.

Other Services Limited occlusal adjustment - limited to one visit, in any 12 consecutive month period.

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth by report

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

B498.1132-R

Option A

Group IV - Orthodontic Services

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

Transseptal fiberotomy

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

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

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

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

B498.0071

CERTIFICATE AMENDMENT

This rider amends this plan's dental expense Appeals section to include the following:

Any case under appeal must be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal must be: (a) a peer of the treating health care provider; (b) board certified in the same or similar specialty as the treating health care provider; and (c) specialized in a discipline pertinent to the issue under review.

A physician advisor or peer of the treating health care provider who renders a decision on appeal must: (a) not have participated in the adverse decision or any prior reconsideration concerning it; (b) not be employed by or a director of the health care review organization (HCRO); and (c) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

B500.0042

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.

B531.0029

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B550.0087

All Options

Order Of Benefit Determination

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

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

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

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

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

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

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

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

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

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

Active Or Inactive Employee

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

Continuation Coverage

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

Length Of Coverage

The plan that covered the person longer is primary.

Other

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

B550.0088

Effect On The Benefits Of This Plan

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

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

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

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.

B550.0089

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B600.0012

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

B900.0118

Option A

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

B750.0663

All Options

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

B750.0664

All Options

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

B750.0665

All Options

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

B750.0666

All Options

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

B750.0667

All Options

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

B750.0668

All Options

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

B750.0669

All Options

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

B750.0670

All Options

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

B750.0671

All Options

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

B900.0003

All Options

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

B750.0015

All Options

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

B750.0672

All Options

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

B750.0006

All Options

Employer means GUEST SERVICES, INC. .

B900.0051

All Options

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

B900.0004

All Options

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

B750.0229

All Options

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

B900.0006

All Options

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

B750.0673

All Options

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

B900.0008

Option A

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

B750.0675

Option 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.*

B750.0685

All Options

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

B750.0676

All Options

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

B750.0677

All Options

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

B750.0679

All Options

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

B750.0678

All Options

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

B750.0681

All Options

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

B750.0682

All Options

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

B750.0008

All Options

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

B750.0683

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

All Options

The Guardian's Responsibilities

B800.0048

All Options

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

B800.0064

All Options

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

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

- the opportunity to submit written comments, documents, records and other information relating to the claim;

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0081

Termination of This Group Plan

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

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

B800.0068

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  GUEST SERVICES, INC. Plan

- **Employer's Name:** (Plan Sponsor)

  GUEST SERVICES, INC.

  Address: 3055 PROSPERITY AVENUE
  FAIRFAX VA 22031

  Phone Number: 703-849-9384

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**

- **Plan Number:** 508

- **Type of Administration:** contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

  GUEST SERVICES, INC.

  Address: 3055 PROSPERITY AVENUE
  FAIRFAX VA 22031

  Phone Number: 703-849-9384

- **Agent for the Service of Legal Process:**

  GUEST SERVICES, INC.

  Address: 3055 PROSPERITY AVENUE
  FAIRFAX VA 22031

  Phone Number: 703-849-9384

  (Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.

- **Date of End of Record Year:** January 1st .

- **Sources of Contribution:**Contributions to the plan are provided by:

  - the Employer

  - the Employee

  - Both the Employer and the Employee (assuming there are situations where both contribute).

- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)

- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.

- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.

- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0383

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of your claim
- Print forms and plan materials
- And so much more!

To register, go to **www.guardianlife.com**

B101.0002

Guardian