YOUR GROUP INSURANCE PLAN BENEFITS

GARLAND INDEPENDENT SCHOOL DISTRICT
DENTAL NAP BOOK

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

Have a complaint or need help?

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

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

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

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

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

The Texas Department of Insurance

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

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

Tiene una queja o necesita ayuda?

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

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

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

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

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

El Departamento de Seguros de Texas

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

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

CERTIFICATE OF COVERAGE

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

The Group Dental Insurance Coverage described in this Certificate is attached to the group Policy effective September 1, 2019. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP DENTAL INSURANCE COVERAGE

Guardian certifies that the Subscriber to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Subscriber must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Subscriber under the Policy; and (c) all required premium payments must have been made by or on behalf of the Subscriber, subject to the Policy's grace period; and (d) satisfy any necessary Proof of Insurability requirements.

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

Policyholder: GARLAND INDEPENDENT SCHOOL DISTRICT
Group Policy Number: 00562276
Effective Date: September 1, 2019

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

THE INSURANCE POLICY UNDER WHICH THIS CERTIFICATE IS ISSUED IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE. YOU SHOULD CONSULT YOUR EMPLOYER TO DETERMINE WHETHER YOUR EMPLOYER IS A SUBSCRIBER TO THE WORKERS' COMPENSATION SYSTEM.

B401.0018

GC-DEN-16-TX

TABLE OF CONTENTS

GENERAL PROVISIONS

Applicable Benefits

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

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

Limitation of Authority

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

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

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

Incontestability

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

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

Grace Period

A grace period of 31 days, without interest charge, will be allowed for each premium payment except the first. If any premium with respect to the Subscribers is not paid before the end of the grace period, the Policy and this Certificate ends with respect to all Subscribers at the end of the grace period. If the Policyholder gives Us advance written notice of an earlier termination date during the grace period, the Policy and this Certificate will end as of such earlier date.

If the Policy and this Certificate ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time this Policy and this Certificate was in force during the grace period.

B401.0025

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL INSURANCE COVERAGE

B400.0018

Subscriber Eligibility

You are eligible for Dental coverage if You are:

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

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

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

B400.0027

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child from the moment of birth, natural child, an adopted child or any child to whom You or Your Spouse are a party to a suit to adopt the child, stepchild, a natural or adopted child of Your Spouse, a grandchild who is dependent on You for federal income tax purposes, a child for whom You are required by court order to provide dental support or a child placed with You for foster care who is under age 26; and
  - A child who is incapable of self-support because of a physical or mental incapacity. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:

- The condition started before he or she reached the age limit; and
- The child remained continuously covered until he or she reached the age limit; and
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Eligible dependent does not include anyone who is insured under this Policy as the Subscriber.

B401.0044

Eligibility Waiting Period

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Policyholder.

B400.0085

When Coverage Starts

Your Policyholder will inform You of Your Effective Date under the Dental Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Dental Policy as stated in the Conditions Of Eligibility for Group Dental Insurance section; and
- You and Your eligible dependents have enrolled in the Dental Policy; and
- Required premiums have been paid.

Newborn Children: Your newborn child is covered automatically from the moment of birth until the child is 31 days old. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of such birth and pay any required premium to have coverage continue beyond the 31 day period.

Adopted Children: Your adopted child is covered automatically for the first 31 days from the date that You or Your Spouse become a party to a suit in which You or Your Spouse seek to adopt the child. Coverage will be the same as for all other covered dependent children. You must notify Us in within 31 days of the date of the adoption and pay any required premium to have coverage continue beyond the 31 day period.

Children who are the Subjects of a Medical Support Order: A child who is the subject of a medical support order to provide dental coverage is covered automatically for the first 31 days from the date of such an order. Coverage will be the same as for all other covered dependent children. You must notify Us within 31 days of the date of the court or administrative order and pay any required premium to have coverage continue beyond the 31 day period.

You and Your eligible dependents may be considered a Late Entrant if You fail to enroll within 31 days of the Eligibility Date or a Qualifying Event. Late Entrant penalties may be imposed. Please refer to Your Schedule of Benefits.

B401.0056

Exception to When Coverage Starts

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

- A holiday;
- A vacation day;
- A non-scheduled work day;

and if:

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

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

B400.0093

When Your Coverage Ends

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

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Subscriber under this Certificate.

- The date the group Certificate ends, or is discontinued for a class of Subscribers to which You belong.
- The last day of the period for which required payments are made for or by You, subject to the Policy's grace period.
- The date You die.

B401.3207

When Your Dependent Coverage Ends

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

- When Your coverage ends.
- When You stop being an eligible Subscriber under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Subscribers to which You belong.
- The last day of the period for which required payments are made for Your dependent, subject to the Policy's grace period.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B401.3223

CONTINUATION OF COVERAGE

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

Continuation Rights

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

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

Uniformed Services Continuation Rights

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

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

You may contact Your Policyholder for additional information.

COBRA Continuation Rights

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

Family Medical Leave Of Absence (FMLA)

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

B400.0118

Dependent Survivorship Benefit

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

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

B400.0122

Texas Continuation Rights

This section applies only to the dental coverages provided by this plan. These coverages are referred to as "group health benefits".

This section does not apply to any coverage which provide benefits for expenses incurred because of a specific disease or accident.

A Covered Person or dependent is entitled to continuation of group health benefits if:

- the individual's coverage under the group policy is terminated for any reason other than involuntary termination for cause, including discontinuance of the group policy in its entirety or with respect to an insured class; and
- the individual has been continuously insured under the group policy, or under any group policy providing similar benefits that the policy replaces, for at least three consecutive months immediately before termination.

Involuntary termination for cause does not include termination for any health-related cause.

A Covered Person or dependent must provide to the Employer or group Policyholder a written request for continuation of group health benefits not later than the 60th day after the later of:

- the date the group health benefits would otherwise terminate; or
- the date the individual is given, in a format prescribed by the commissioner, notice by either the Employer or the group Policyholder of the right to continuation of group health benefits.

Except as provided by this section, a Covered Person, or dependent who elects to continue group coverage must pay to the Employer or group Policyholder each month the amount of contribution required by the Employer or Policyholder, plus two percent of the group rate for the coverage being continued under the group policy. A payment under this section must be made not later than the 45th day after the date of the initial election for coverage and on the due date of each payment thereafter. Following the first payment made after the initial election for coverage, the payment of any other premium shall be considered timely if made on or before the 30th day after the date on which the payment is due. Group health benefits continued under this subchapter may not terminate until the earliest of:

- the date the maximum continuation period provided by law would end, which is:
  - for any Covered Person, or dependent not eligible for continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA), nine months after the date the Covered Person, or dependent elects to continue the group health benefits; or
  - for Covered Person or dependent eligible for continuation coverage under COBRA, six additional months following any period of continuation coverage provided under COBRA;
- the date failure to make timely payments would terminate the group health benefits;
- the date the group health benefits terminate in its entirety;
- the date the Covered Person or dependent is or could be covered under Medicare;
- the date the Covered Person or dependent is covered for similar benefits by another plan or program, including:
  - a hospital, surgical, medical, or major medical expense insurance policy;
  - a hospital or medical service subscriber contract; or
  - a medical practice or other prepayment plan;
- the date the Covered Person or dependent is eligible for similar benefits, whether or not covered for those benefits, under any arrangement of coverage for individuals in a group, whether on an insured or uninsured basis; or
- the date similar benefits are provided or available to the Covered Person or dependent under any state or federal law other than continuation coverage under Title X, Consolidated Omnibus Budget Reconciliation Act of 1985 (29 U.S.C. Section 1161 et seq.) (COBRA).

Not later than the 30th day before the end of the continuation period described above that is applicable to the Covered Person or dependent, the insurer shall:

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

B401.0094

Texas Continuation Rights for Dependents: This section applies only to the dental coverages provided by this plan if coverage under this plan ends because of:

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

These coverages are referred to as "group health benefits".

A dependent of an insured is eligible for continued group health benefits under this subchapter if the dependent:

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

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

An individual covered under group continuation coverage is entitled to coverage that is identical in scope to the group health benefits provided under this plan. No additional exclusions that were not included in this plan will be included in the group continuation coverage.

If the group Policyholder replaces this plan within the period described below, a dependent covered under group continuation coverage may obtain group health benefits identical in scope to the group health benefits under the replacement group policy.

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

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

At the time this plan is issued, the group Policyholder is required to give written notice of this continuation to each Covered Person and each dependent of a Covered Person.

We require a Covered Person to give written notice to the group Policyholder not later than the 15th day after the date of any severance of the family relationship that might activate the continuation option. Written notice may be given by the Covered Person’s dependent.

On receipt of notice, the group Policyholder shall immediately give written notice of the continuation option to each affected dependent of the Covered Person.

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

Not later than the 60th day after the date of the severance of the family relationship or the retirement or death of the Covered Person, a dependent must give written notice to the group Policyholder of his or her desire to exercise the continuation option. Coverage under this plan remains in effect during the period if the plan's premiums are paid.

If a dependent does not give written notice of his or her desire to exercise the continuation option within the time period, the option expires.

Any period of previous coverage under this plan, must be used in full or partial satisfaction of any required probationary or waiting periods for dependent coverage.

If this plan provides to a Covered Person continuation rights to cover the period between the time the Covered Person retires and the time the Covered Person is eligible for coverage by Medicare, the same continuation rights are available to the Covered Person's dependents.

The group health benefits of a Covered Person or dependent who exercises the continuation option continues without interruption and may not be canceled or otherwise terminated until:

- the Covered Person or dependent fails to make a premium payment within the time required to make the payment;
- the Covered Person or dependent becomes eligible for substantially similar coverage under another plan or program, including a group health insurance policy or contract, hospital or medical service subscriber contract, or medical practice or other prepayment plan; or
- the third anniversary of:
  - the severance of the family relationship; or
  - the retirement or death of the Covered Person.

B401.0095

DENTAL CLAIM PROVISIONS

You may visit any Dentist. After Guardian pays its portion of the Covered Charges, You are responsible for the rest. This includes any Deductible, Copayment, Coinsurance and amounts above any coverage maximum, as well as, any remaining charges up to the Dentist's total charge for services received.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on a percentile of the prevailing fee data for the Dentist's zip code. Please refer to Your Schedule of Benefits.

B400.0177

Filing A Claim

Most Dentists file claims electronically or have claim forms on hand. If they don't, You may obtain one by visiting our website at www.GuardianAnytime.com or You may call our customer service department at (800) 541-7846 or the toll-free number listed on Your ID card. We will furnish You a claim form within 15 days of Your request.

If You have services performed by a Guardian Contracted Dentist, Your claim will be submitted for You and the payment will be sent directly to Your Dentist.

If You have services performed by a Non-Contracted Dentist, You may need to submit Your own claim. Just follow these easy steps to ensure efficient processing:

- Complete Your portion of the claim form and present the form to the Dentist for completion.
- Mail Your completed claim form to the address shown on the Guardian claim form or You can obtain our address on the Guardian website at www.GuardianAnytime.com.

Proof Of Claim

Written proof of claim must be furnished to Guardian within 90 days from the date the service is performed. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than 12 months from the date proof of claim is otherwise required.

We may require additional information to pay Your claim. This may consist of existing radiographic images, periodontal charting, narratives and other existing diagnostic materials that may support Your claim.

B401.0098

A Covered Person may have dental insurance through multiple plans. When that occurs one plan is determined to be primary while the other is deemed to be secondary.

Rules to make the primary/secondary determination are:

- The plan without a coordination provision is always primary.
- If a medical plan provides coverage for the dental service, that plan is primary. This excludes Affordable Care Act (ACA) compliant plans.
- If both plans have a COB provision, the plan providing coverage to the Subscriber is primary.
- A plan that provides coverage for an active Subscriber will be primary over a retiree plan.
- If a child is covered under both parents' plans:
  - When the parents are living together, the plan of the parent whose birthday is earlier in the year is primary.
  - When the parents are separated and not living together:
    - Any applicable court order will apply.
    - With 50/50 custody situations, the plan of the parent whose birthday is earlier in the year is primary.
    - With no court order, benefits will be coordinated in the following order: (1) natural parent with custody; (2) step parent with custody; (3) natural parent without custody; and (4) step parent without custody.
- When none of these rules apply, the plan that has provided coverage the longest is primary.

When Guardian is primary, benefits are determined as if no other plan exists.

When Guardian is secondary, benefits are determined so that the total payable by both plans does not exceed the allowable amount, (described below):

- If both plans are subject to a contracted fee schedule, the higher fee schedule is the allowable amount.
- If only one plan is subject to a contracted fee schedule:
  - When the primary plan is not subject to a fee schedule, Guardian's fee schedule is the allowable amount.
  - When the primary plan is subject to a fee schedule, the primary plan's fee schedule is the allowable amount.

- If neither plan is subject to a contracted fee schedule, the maximum allowed amount of either plan is the allowable amount.

In no instance will Guardian pay more as the secondary plan than it would have paid being the primary plan.

B400.0185

How We Pay Orthodontic Claims

Orthodontic services may or may not be covered under this Policy. Please refer to Your Schedule of Benefits.

Benefits for orthodontic claims are divided into equal payments, which will be paid over the lesser of: (a) the length of the treatment plan; or (b) two years. The first payment is made when the Appliance is placed. Remaining payments are made at the end of each quarter.

If Your orthodontic treatment began prior to Your Eligibility Date, benefits will be prorated by the portion of the treatment incurred while insured with Guardian.

Any orthodontic Lifetime maximum amount paid under a Prior Policy, will be deducted from this Policy's orthodontic Lifetime Maximum.

B400.0188

DENTALGUARD PREFERRED - THIS PLAN'S CONTRACTED PROVIDER ORGANIZATION (CPO) INSURANCE

This Policy's benefits are paid the same for Covered Charges furnished by Contracted Dentists and Non-Contracted Dentists, however, a Covered Person will usually be left with less out-of-pocket expense when a Contracted Dentist is used.

Guardian's Contracted Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers as shown below. Network access varies by geographic location and zip code. Please visit www.GuardianAnytime.com to confirm your Dentist's tiered participation.

- DentalGuard Preferred Gold
- DentalGuard Preferred Silver

B401.0111

Contracted Dentists

Dentists who are contracted with Guardian's DentalGuard Contracted Provider Organization have agreed to accept a discount for the Covered Services they perform. When You visit one of these Dentists, the discount will lower Your out-of-pocket costs.

When receiving services from a Contracted Dentist, You will be responsible for any Deductible, Copayment, Coinsurance amounts above the Benefit Year Maximum and for any non-covered services. In some instances, You may be responsible for the difference between the Dentist's discounted fee and the plan allowance. For Covered Services, You will not be responsible for amounts above the Dentist's discounted fee.

Some states allow Contracted Dentists to accept discounts only on services that are covered by the Policy. Prior to Your anticipated dental services being performed, ask Your Dentist for a treatment plan that includes services to be provided with an estimated cost. (Please see Pre-Treatment Review section). If You would like more information, You may call our customer service department at (800) 541-7846 or the toll-free number listed on Your ID card.

You will need to verify if Your Dentist is contracted within Guardian's Dental Contracted Provider Organization at the time of service.

Please refer to Guardian's on-line provider directory at www.GuardianAnytime.com.

If Your Policy provides orthodontics, the negotiated discounted fee for orthodontics does not include:

- Any incremental charges for optional orthodontic Appliances.
- Replacement or repair due to neglect of the patient.
- Treatment plans that began prior to the Eligibility Date.

B401.0112

Non-Contracted Dentists

You may visit any Dentist. After Guardian pays its portion of Covered Charges, You are responsible for the rest. This includes Your Deductible, Copayment, Coinsurance and amounts above the Benefit Year Maximum, as well as, any remaining charges up to the Dentist's total charge for services received. But, in no event will the payment for services received from a Non-Contracted Dentist be less than the payment would be if the same services were received from a Contracted Dentist.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on a percentile of the prevailing fee data for the Dentist's zip code. Please refer to Your Schedule of Benefits.

B401.0113

Appeal Process

Definitions

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

Adverse Determination: This term means a determination by a utilization review agent (URA) that the dental care services provided or proposed to be provided to the Covered Person are not medically necessary or are experimental or investigational.

Certification: This term means a determination that the dental care services being provided or proposed to be provided to a Covered Person meet the criteria for medical necessity and appropriateness.

Clinical Peer: This term means a Dentist or dental care professional in the same or similar specialty, who typically manages the dental condition, procedure or treatment under review.

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

Department: This term means the Texas Department of Insurance.

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

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

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

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

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

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

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

B401.0114

Utilization Review Determinations

When the initial determination is certification, written notification will be sent to a Covered Person and the Covered Person's Dentist within two working days of making the determination.

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

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

The URA will make an initial determination in a retrospective review within 30 days of receipt of all information needed to complete the review. This period may be extended once by the URA for a period not to exceed 15 days, if the URA:

- determines that an extension is necessary due to matters beyond the URA's control; and
- notifies the Dentist of record and the Covered Person before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the URA expects to make a determination.

If the extension is required because of the failure of the Dentist of record or the Covered Person to submit information necessary to reach a determination on the request, the notice of extension must:

- specifically describe the required information necessary to complete the request; and

- give the Dentist of record and the Covered Person at least 45 days from the date of receipt of the notice of extension to provide the specified information.

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

- the date on which the Dentist of record or the Covered Person responds to the request for additional information; or
- the date by which the specified information was to have been submitted.

Notice of adverse determination will include:

- the principal reasons for the adverse determination;
- the clinical basis for the adverse determination;
- a description of the source of the screening criteria that were used in making the determination;
- a description of the complaint and appeal process; and
- the independent review notification procedures, and the independent review request form.

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

B401.0115

Internal Appeals

A Covered Person, a person acting on the Covered Person's behalf, or the Covered Person's Dentist may appeal an adverse determination orally or in writing.

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

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 2457
Spokane, WA 99210-2457

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

A licensed Dentist will review the appeal and render a decision.

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

A licensed Dentist will review the appeal and render a decision.

Notification of that decision will be mailed to the Covered Person or a person acting on behalf of the Covered Person and to the Covered Person's Dentist within 30 days of receipt of the request for standard appeal.

If the appeal is denied, the notice will include:

- a statement of the specific reasons for the resolution;
- the clinical basis for such decision;
- the specialization of any Dentist consulted; and
- in the case of a denial, notice of the appealing party's right to seek independent review of the denial and the procedure for obtaining that review, including the necessary forms.

If the appeal is denied, the Covered Person's Dentist may request, in writing, a review of the denial by a Dentist in the same or similar specialty as typically manages the condition, procedure, or treatment under review. This request must: (a) be made within 10 working days of the denial of the appeal; and (b) set forth good cause for having a particular type of specialty Dentist review the case. The specialty review will be completed within 15 working days of receipt of the request.

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

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 2457
Spokane, WA 99210-2457
Phone: (800) 541-7846
Fax: (509) 468-6123

A licensed Dentist or licensed dental care professional who typically manages the dental condition under review and who did not previously review the case will review the appeal.

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

The Covered Person and the Covered Person's Dentist will be notified by telephone or electronic transmission within one working day of making the decision. Written confirmation will also be sent to the Covered Person or a person acting on behalf of the Covered Person.

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

- a statement of the specific reasons for the resolution;

- the clinical basis for such decision;
- the specialization of any Dentist consulted; and
- in the case of a denial, notice of the appealing party's right to seek independent review of the denial and the procedure for obtaining that review, including the necessary forms.

B401.1715

External Appeals

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

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 2457
Spokane, WA 99210-2457
Phone: (800) 541-7846
Fax: (509) 468-6123

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

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

- any relevant medical records;
- any relevant portions of the utilization review plan used in making the decision;
- a copy of the written notice of the appeal's denial;
- any documentation and written information submitted by the appealing party in support of the appeal; and
- a list of the names, addresses, and phone numbers of each Dentist who has provided care to the Covered Person and who may have dental records relevant to the appeal.

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

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

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

The IRO should notify the Covered Person or person acting on behalf of the Covered Person and the Covered Person's Dentist of the decision.

This Policy must cover charges for any Covered Services determined to be medically necessary or appropriate by the IRO. And, this Policy will pay the cost of the external review.

B401.1716

COVERED CHARGES

To be a Covered Charge, the service must be:

- Performed by a licensed Dentist; and
- Necessary and appropriate for Your condition; and
- An eligible Covered Service as described in the Schedule of Benefits.

We may use the professional review of a licensed Dentist to determine the appropriate benefit for a dental procedure or course of treatment. We may apply an Alternate Treatment benefit when a less expensive service can be used to treat the dental condition.

Certain comprehensive dental services have multiple procedures. For benefit purposes, these separate procedures will be considered part of the more comprehensive service.

You and Your Dentist have the right and responsibility for choosing the course of treatment and the services to be performed, regardless if those services are covered under this Policy. Once services have been performed and the claim submitted, We will review the claim and determine the benefits payable under this Policy.

All covered charges are considered incurred on the date services are furnished, with the following exceptions:

- Charges for crowns, bridges and other cast restorations are incurred on the date the tooth is initially prepared.
- Charges for root canals are incurred on the date the pulp chamber is opened.
- Charges for dentures are incurred on the date the final impression is made.
- The initial charge for orthodontic treatment is incurred on the date the Appliance is first placed.

Please refer to Your Schedule of Benefits.

B400.0191

Pre-Treatment Review

To assist You in managing Your total costs, Guardian offers a "Pre-Treatment Review".

A Dentist may submit a treatment plan to Guardian for review before services are performed. Guardian will advise the patient and the Dentist what services are covered and what the estimated payment would be. The actual payment for the predetermined services depends on eligibility, Policy limitations, Coordination of Benefits and the remaining maximum available at the time services are performed. A Pre-Treatment Review is subject to change based on the Dentist's participation status at the time of treatment. A Pre-Treatment Review is optional, however it is strongly recommended for non-routine dental services. Once the services are completed, the claim should be submitted to Guardian for payment.

B400.0192

Benefit Year Maximum Rollover

A portion of a Covered Person's unused Benefit Year Maximum may be rolled over into a maximum rollover account.

At the beginning of each Benefit Year, a maximum rollover reward will be made, provided:

- The Covered Person had a claim incurred and paid during the prior Benefit Year.
- The Covered Person's paid claims for the prior Benefit Year did not exceed the rollover threshold amount.
- The Covered Person must have been eligible for major service coverage at the end of the prior Benefit Year. Please refer to your Schedule of Benefits for covered major services.
- The Covered Person must have been insured with the rollover provision prior to October of the prior year.

The amount of any maximum rollover reward is listed in the Schedule of Benefits.

If a Covered Person reaches his or her Benefit Year Maximum, We will pay additional benefits up to the amount stored in the Covered Person's rollover account. Rollover benefits are not available for orthodontic services. The amount stored in the rollover account cannot be greater than the rollover account maximum.

The rollover threshold, maximum rollover reward, and the rollover account maximum are listed in the Schedule of Benefits.

A Covered Person's rollover account will be eliminated and any accrued rollover lost, if he or she has a break in coverage of any length of time, for any reason.

B400.0222

Replacing a Prior Policy

If this Policy is replacing a Prior Policy, in the first Policy year; (a) We will reduce the Deductible amount applied under the Prior Policy from this Policy's Deductible; and (b) the maximum amount paid under the Prior Policy will be deducted from this Policy's Benefit Year Maximum. Documentation for Prior Policy benefits must be provided.

B400.0193

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.0292

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

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

B400.0293

Alternate Treatment: This term means 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 through the professional review of a licensed Dentist.

B400.0294

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

B400.0295

Appliance: This term means any dental device other than a Dental Prosthesis.

B400.0296

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

B400.0361

Benefit Year Maximum: This term means the total dollar amount that Guardian will pay for Covered Services by a Covered Person in a Benefit Year.

B400.0298

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

B400.0299

Coinsurance: This term means the percent of the benefit that Guardian will pay after the required Deductible has been met.

B400.0303

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Guardian to participate in Guardian's dental network.

B400.0300

Copayment: This term means a fixed dollar amount that the Covered Person is required to pay at the time services are rendered.

B400.0304

Covered Person: This term means You, if You are covered by this Policy, and any of Your covered dependents.

B400.0301

Covered Services: This term means services for which any reimbursement is available under the Subscriber's Certificate of Coverage, regardless of whether the reimbursement is contractually limited by a Deductible, Copayment, Coinsurance, service waiting period, Benefit Year Maximum or Lifetime Maximum, frequency, alternate benefit payment, or other limitations.

B400.0302

Deductible: This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B400.0305

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

B400.0306

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

B400.0307

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Policyholder and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B400.0308

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

B400.0309

Full-time: This term means:

You work at least the minimum required number of hours for the Subscriber in Your eligible class (but not less than 10 hours per week), at:

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

B400.0315

Injury: This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Policy; and (2) all complications arising from that damage. But the term does not include damage to teeth, Appliances or Dental Prostheses which results solely from chewing or biting food or other substances.

B400.0316

Late Entrant: This term means a person who: (1) becomes covered by this Policy more than 31 days after the Covered Person is eligible; or (2) becomes covered again, after the Covered Person's coverage lapsed because he or she did not make required payments.

B400.0319

Lifetime Maximum: This term means the maximum amount that Guardian will pay for Covered Services during a Covered Person's lifetime.

B400.0320

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Guardian to provide dental services

B400.0321

Policy: This term means the group Dental Insurance Coverage described in the Policy and this Certificate.

B400.0324

Policyholder: This term means the entity that purchased this Policy.

B400.0325

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

B400.0326

Prior Policy: This term means the Policyholder's plan of group dental coverage which was in force immediately prior to this Policy. For a plan to be considered a Prior Policy, the Guardian Policy must start immediately after the prior coverage ends.

B400.0327

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

B400.0329

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

B400.0331

Subscriber: This term means the member of the group determined to be eligible by the Policyholder.

B400.0332

We, Us, Our and Guardian: These terms mean The Guardian Life Insurance Company of America.

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

B400.0333

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

OPTION A

GROUP DENTAL INSURANCE COVERAGE
SCHEDULE OF BENEFITS

This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

Tier Configuration	DentalGuard Preferred Alliance Select Dentists DentalGuard Preferred Elite Dentists DentalGuard Preferred Connect Dentists DentalGuard Preferred Plus Dentists Non-Contracted Dentists

Guardian's Contracted Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.GuardianAnytime.com to confirm your Dentist's tiered participation.

Covered Charges Reimbursement	DentalGuard Preferred Alliance Select - Contracted Fee Schedule DentalGuard Preferred Elite - Contracted Fee Schedule DentalGuard Preferred Connect - Contracted Fee Schedule DentalGuard Preferred Plus - Contracted Fee Schedule Non-Contracted Dentist - The 90th percentile of the prevailing fee data for the Dentist's zip code.
Dependent Child Age Limit	26

PLAN BENEFITS

Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.

BENEFIT YEAR DEDUCTIBLE

Individual Benefit Year Deductible - A covered family must meet three Individual Benefit Year deductibles in a Benefit Year	$50.00
Deductible Waived for Preventive Services	Yes
Deductible Waived for Basic Services	No
Deductible Waived for Major Services	No
Deductible Waived for Orthodontic Services	Yes

COINSURANCE

COINSURANCE (Cont.)	
Preventive Services	100%
Basic Services	80%
Major Services	50%
Orthodontic Services	50%
BENEFIT YEAR MAXIMUM	
Individual Benefit Year Maximum	$1,250.00
LIFETIME MAXIMUM	
Orthodontic Lifetime Maximum	$1,000.00
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.	
BENEFIT YEAR MAXIMUM ROLLOVER	
Rollover Threshold	$600.00
Maximum Rollover Reward	$300.00
Rollover Account Maximum	$1,250.00
LATE ENTRANT PENALTIES	
Preventive Services	None
Basic Services	None
Major Services	None
Orthodontic Services	None

COVERED DENTAL SERVICES

The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 2 in a calendar year. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Basic	Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 36 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, twice in a calendar year.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Basic	Limited to one test in any 24 consecutive month period for Covered Persons age 40 and older.
Diagnostic casts	Orthodontic	
Prophylaxis	Preventive	Limited to 2 prophylaxes or periodontal maintenance in a calendar year.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 2 in a calendar year. Limited to covered persons up to age 19.
Sealants	Preventive	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.
Space maintainers	Preventive	Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Minor treatment to control harmful habits	Orthodontic	For Covered Persons up to age 26. Limited to thumbsucking Appliances.
RESTORATIVE		
Amalgam restorations	Basic	
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, polishing and local anesthetic.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Inlays, Onlays, Labial veneers	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Veneers are limited to anterior and bicuspid teeth only. **See Dental Prosthesis replacement limitation below.** Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Post and core, Core buildup	Major	Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation below.**
Crown repair, Bridge repair	Basic	

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Basic	
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Major	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Major	Covered when root canal therapy is not the definitive treatment.
Root canal/endodontic therapy, anterior and bicuspid teeth	Major	
Root canal/endodontic therapy, molar teeth	Major	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Major	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Major	Limited to once per tooth.
Apicoectomy, Root amputation, Retrograde filling	Major	Each limited to once per root.
Other endodontic services	Major	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Preventive	Limited to 2 prophylaxes or periodontal maintenance in a calendar year.
Periodontal scaling and root planing	Major	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Major	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Major	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Major	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Major	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present.
Guided tissue regeneration	Major	Limited to once per area or tooth, when the tooth is present.
Bone replacement graft	Major	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Major	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Major	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		
Fixed partial denture retainer crowns and pontics (Bridge)	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.** Each retainer and each pontic makes up a unit on a bridge. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Dentures, complete and partial	Major	Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures, and interim dentures older than 1 year are considered to be a permanent Dental Prosthesis. Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
Adding teeth to partial dentures	Basic	To replace extracted natural teeth. **See missing tooth provision below.**

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Denture repairs	Basic	
Denture rebase	Basic	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to rebases done more than 12 months after the insertion of the denture.
Denture reline	Basic	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to relines done more than 12 months after the insertion of the denture.
Denture adjustments	Basic	Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Limited to adjustments done more than 6 months after a denture rebase, denture reline or the initial insertion of the denture.
Tissue conditioning	Basic	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in 12 months.
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Not Covered	
Surgical placement of implant	Not Covered	
Bone replacement graft for ridge preservation, per site	Not Covered	
Prefabricated abutment, Custom fabricated abutment	Not Covered	
Repair implant supported prosthesis	Not Covered	
Repair implant abutment	Not Covered	
Implant removal	Not Covered	
Implant/abutment supported crown or retainer for fixed partial denture	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. **See Dental Prosthesis replacement limitation and missing tooth provision below.**

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Major	Limited to permanent teeth only. **See Dental Prosthesis replacement limitation and missing tooth provision below.**
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Major	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.
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Major	Allowance includes diagnostic and treatment radiographic images, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Basic	Covered in conjunction with covered surgical services.
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
ORTHODONTICS		
Limited orthodontic treatment, Interceptive orthodontic treatment, Comprehensive orthodontic treatment	Orthodontic	Allowed on dependent children up to age 26. Coverage includes treatment plan and records, including initial, interim and final records. Fabrication and insertion of Appliances and periodic visits. Orthodontic retention, including fixed and removable initial Appliances and related visits. Surgical placement of temporary anchorage device. Transseptal fiberotomy.
TEMPOROMANDIBULAR JOINT DYSFUNCTIONS (TMJ)		

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Diagnostic and surgical treatment of Temporomandibular Joint Dysfunctions (TMJ)	Major	Coverage is limited to the necessary diagnostic and surgical treatment of temporomandibular and craniomandibular joint dysfunctions. We cover charges for such conditions as a result of: (1) an accident, (2) a trauma, (3) a congenital defect, (4) a developmental defect, or (5) a pathology. We treat such services the same way We treat any other covered charges for Major services. Subject to the deductible for Major services and all other terms of this Plan, We pay benefits for such covered charges at a payment rate of 50%. We do not cover the medical treatment of the temporomandibular joint. Services listed in this category and related services, may be covered by Your medical plan.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any 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 covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
Treatment for which no charge is made. This usually means treatment furnished by: (1) the Covered Person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
Treatment needed due to: (1) an on the job or job related Injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
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.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

CERTIFICATE AMENDATORY RIDER

This Rider amends this Certificate by replacing the Grace Period In Payment Of Premiums Termination Of Group Certificate provision as shown below and is effective on its issue date.

Grace In Payment Of Premiums - Termination Of Certificate

A grace period of 60, without interest charge, will be allowed for each premium payment except the first. If any premium is not paid before the end of the grace period, this Certificate ends at the end of the grace period. If You give Us advance written notice of an earlier termination date during the grace period, the Certificate will end as of such earlier date.

If the Certificate ends during or at the end of the grace period, You will still owe Us premium for all the time the Certificate was in force during the grace period.

The Certificate ends immediately on any date when an insurance coverage under the Certificate ends and, as a result, no benefits remain in effect under the Certificate.

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

The Guardian Life Insurance Company of America

Michael Prestileo,
Senior Vice President

Harris Oliner
Senior Vice President and
Corporate Secretary

B401.3521

GC-A-GRACE-18-TX-ER

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

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

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

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

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

Dental Benefits Claims Procedure

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

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

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

B405.0447

Definitions

"Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing For Initial Benefit Determination

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

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

A notification of an extension to the time period in which a Benefit Determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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

Adverse Benefit Determination

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

- The specific reason(s) for the Adverse Benefit Determination;

- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan s review procedures and the time limits applicable to such procedures, including a statement of the claimant s right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

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

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the Adverse Benefit Determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant s claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options

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

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YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

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

To register, go to www.GuardianAnytime.com

Guardian

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001