YOUR
GROUP INSURANCE
PLAN

SAINT MARY'S COLLEGE OF CALIFORNIA

CLASS 0001

DENTAL, VISION

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.

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017
1-800-273-3330

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

The Group Dental Coverage described in this Evidence of Coverage is attached to the group policy "Policy" effective January 1, 2025. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Policy or under any other policy providing similar or identical benefits issued to the Policyholder by Us.

Managed Dental Care (MDC) of California is a California corporation, licensed as a Knox-Keene Heath Care Service Plan under applicable California law, whose primary purpose is to operate a dental care service plan.

MANAGED DENTAL CARE PLAN

GROUP CONTRACT FOR PREPAID DENTAL SERVICES

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHAT IT COVERS, LIMITS, AND EXCLUDES.

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

The Employee 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: SAINT MARY'S COLLEGE OF CALIFORNIA
Group Policy Number: 00072651

Effective Date: January 1, 2025
Managed Dental Care of California

Jill M. Purcell, President

Thomas S. Barnes, Controller

B425.1256

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GENERAL PROVISIONS

Applicable Benefits

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

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

B425.0637

Option B

Public Policy Committee

MDC maintains a Public Policy Committee composed of at least three Members, one Contracted Dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee. MDC communicates material changes affecting public policy to Members in periodic newsletters.

B425.0638

Option B

Confidentiality

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

You may contact Our customer services department at the address below to request a copy of the Policy's confidentiality statement. The confidentiality statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

We will direct all confidential communications regarding your receipt of Sensitive Services directly to you. Confidential communications include bills, explanation of benefits, claims, information regarding a session, or other communications containing medical information or provider name and address related to dental services, including information relating to Sensitive Services, that you have received. Unless otherwise directed by you, we will communicate confidential information to you by contacting you at the mailing address, email address, or telephone number on file. If you would like to receive confidential communications in a specific form and format or at an alternative location, please submit a request as follows:

Customer Services Department
P.O. Box 25256
Lehigh Valley, PA 18002-5256
1-800-273-3330

We will accommodate and implement requests for confidential communications in the form and format requested by you, if confidential communications are readily producible in the requested form and format or at alternative locations. We will acknowledge your request for a confidential communication and advise you of the status. We will provide you with confidential communications within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt of a request by mail. Your request for a confidential communication will be valid until you revoke your request, or you submit a new request for a confidential communication.

We will not disclose medical information related to Sensitive Services you receive to your policyholder, the primary subscriber, or any other member, absent your express written authorization to do so. You are not required to obtain authorization from your policyholder, the primary subscriber, or any other member in order for you to receive Sensitive Services or to submit a claim for Sensitive Services.

B425.1254

Option B

Limitation of Authority

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

- Determine whether any contract, Policy or Evidence of Coverage is to be issued;
- Waive or alter any contract, Policy or Evidence of Coverage, or any of Our requirements;
- Bind Us by any statement or promise relating to the Policy 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.

B425.0640

Option B

Incontestability

All statements made on Your enrollment form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. No statement contained in Your enrollment form will void Your coverage or reduce Your benefits after Your coverage has been in force for two years. Within the first two years of issuance of coverage under this Policy, We may rescind Your coverage based on any fraudulent statement or intentional misrepresentation of material fact made on Your signed enrollment application.

The statements and information contained in the Your enrollment form are represented by You to be true and correct and incorporated into the Policy. You also recognize that MDC has issued the Policy in reliance on those statements and information. The Policy replaces and cancels all other contracts, if any, issued to You by Us.

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

B425.1024

Option B

Language Assistance

As an MDC Member, You have a right to free language assistance services, including interpretation and translation services. MDC collects and maintains Your language preferences, race, and ethnicity so that We can communicate more effectively with Our Members. If You require spoken or written language assistance or would like to inform MDC of Your preferred language, please contact Us at 1-800-273-3330. TDD/TTY for the hearing impaired is available through 1-800-947-6644.

B425.1026

Option B

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Option B

Enrollment Procedures

You may enroll for dental coverage by:

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

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

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

B425.1038

Option B

Open Enrollment Period

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

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

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

B425.1027

Option B

Employee Eligibility

You are eligible for dental coverage if You are:

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

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

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

B425.0656

Option B

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
  - A child who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Employee for support and maintenance, may remain eligible for dependent benefits past the age limit, subject to the following:

- We will send notice to You at least 90 days prior to the limiting age and You must send Us written proof that the child is dependent upon You for support and maintenance as is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. You have 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the childs eligibility is made. We can ask for periodic proof that the childs condition continues, but We cannot ask for this proof more than once a year after the two-year period following the childs attainment of the limiting age.

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

B425.1047

Option B

When Coverage Starts

Your Employer 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 Coverage section; and
- You and Your eligible dependents have enrolled in the dental Policy; and
- Required premiums have been paid.

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

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

B425.0392

Option B

Exception to When Coverage Starts

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

- A holiday;
- A vacation day;

- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

And if:

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

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

B425.0674

Option B

Termination of Coverage

In the event of cancellation by either Us (except in the case of fraud or deception in the use of services or facilities of MDC or knowingly permitting such fraud or deception by another) or You, We shall within 30 days return to You any pro rata portion of fees paid by You which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due.

Termination by You
You may cancel your coverage at any time during the grace period outlined below or by giving Us 31 days advance written notice. This notice must be sent to Our office. The Policyholder will owe Us all unpaid premiums for the period that coverage is in force.

Termination by MDC
We shall have the right to cancel Your coverage upon providing written notice to the Policyholder, who is required to promptly send such notice to You, in the following circumstances:

- Termination by MDC for Non-payment of Premium. We may cancel or decline to renew Your coverage for cause if the Policyholder fails to pay all premiums in accordance with the following terms and conditions:

- A grace period of 30 days, starting after the last date of paid coverage, will be allowed for outstanding premium payments. You will receive a written notice stating the start and end dates of the grace period from the Policyholder.
- If the Policyholder, or another party acting on the Policyholders behalf, makes the necessary premium payment and that payment is received on or before the last day of the grace period, We shall ensure that coverage is not cancelled or not renewed on account of non-payment of such premiums.
- If any premium with respect to the Members covered by the Policy is not paid before the end of the grace period, coverage ends with respect to all Members covered by the Policy immediately following the end of the grace period. You will receive a written notice of end of coverage no later than five (5) business days following the last day of paid coverage from the Policyholder.
- If the Policyholder give Us advance written notice of an earlier termination date during the grace period, Your coverage will end as of such earlier date.
- If Your coverage ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy was in force during the grace period.

- Termination by MDC for Intentional Misrepresentation of Material Fact by You. We may cancel or decline to renew Your coverage if We demonstrate an intentional misrepresentation of a material fact by You or the Policyholder in obtaining Your coverage. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC for Violation of Material Provision Relating to Employer Contributions or Group Participation Rates. We may cancel or decline to renew Your coverage if the Policyholder violates a material provision of the Policy relating to employer contributions or group participation rates. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC Due to Cessation of Services in the State or Withdrawal of Policy from the Market. Subject to providing 180 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the cancellation or nonrenewal is due to MDC ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this State pursuant to Health and Safety Code section 1365(a)(5). Subject to providing 90 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the MDC withdraws the health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6).

If You believe that Your coverage has been or will be improperly canceled, rescinded, or not renewed, You may file request a review by the Department of Managed Health Care, within 180 days of receipt of the notice of cancellation, pursuant to Section 1368 of the Health and Safety Code. Such request for review may be submitted directly to the Department of Managed Health Care by mail to the attention of the Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725; by phone at 1-888-466-2219/TDD 1-877-688-9891; by fax at 1-916-255- 5241; or online at www.healthhelp.ca.gov. Such review shall be in accordance with Sections 1368 and 1365(b) of the Health and Safety Code.

B425.1029

Option B

When Your Dependent Coverage Ends

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

- When Your Coverage ends.
- When You stop being an eligible Employee under this Evidence of Coverage.
- The date the group Evidence of Coverage ends, or dependent Coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- 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.

B425.0692

Option B

CONTINUATION OF COVERAGE

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

B425.0696

Option B

Continuation Rights

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

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

B425.0071

Option B

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 Employer for additional information.

B425.0078

Cal-COBRA 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 to the dental benefits of this Policy. In this section, these benefits are referred to as "group dental benefits."

Under this section, a "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this Policy as: (a) an active, covered Employee; (b) the spouse of an active, covered Subscriber; or (c) the dependent Child of an active covered Employee. A child born to, or adopted by, the covered Employee during a continuation period is also a qualified beneficiary if the child is enrolled in the Policy as a dependent within 30 days of the child's birth or placement for adoption. Any other person who becomes covered under this Policy during a continuation period provided by this section is not a qualified beneficiary.

A qualified beneficiary will be eligible for continuation coverage without demonstrating evidence of insurability upon certain "qualifying events." "Qualifying events" are defined as: (a) the death of the covered Employee; (b) the termination or reduction of work hours of the covered Employees employment, if he or she was not terminated for gross misconduct; (c) the divorce or legal separation of the covered Employee from the covered Employees spouse; (d) the loss of dependent status by a dependent enrolled in the group Policy; and (e) the covered Employees eligibility for coverage under Medicare.

Conversion: Continuing the group health benefits does not stop a qualified beneficiary from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this Policy in force at the time the continuation ends.

If Your Group Health Benefits End: If Your group dental 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 beneficiary; and (b) is subject to "When Continuation Ends."

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary 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 the Employees termination of employment or reduction of work hours, he or she 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, the qualified beneficiary must give Your Employer written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified beneficiary is determined to be disabled. If, during this extra 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify You within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

An additional 50% of the total premium charge also may be required from the qualified beneficiary by the insurer during this extra 11 month continuation period.

If You Die While Insured: If You die while insured, any qualified beneficiary 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 beneficiary whose group dental 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 Loses Eligibility: If a dependent child's group dental 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 beneficiary. 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 dental benefits due to Your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the dependent becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (ii) You become entitled to Medicare.

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 Your dependents. The continuation period, after Your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months 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.

B425.0699

Option B

The Qualified Beneficiary'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; or (b) the loss of dependent eligibility, as defined in this Policy, of a dependent.

Such notice must be given to Your Employer within 60 days of either of these events. Employee must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the Employer if the Policy has contracted with the Employer for administrative service, within the 60-day period following the later of (1) the date that the Employees coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the Employee was sent notice of that ability to continue coverage under the group benefit plan. A qualified beneficiary electing continuation shall pay to the Policy, in accordance with the terms and conditions of the Policy Contract, which shall set forth in the notice to the qualified beneficiary, the amount of the required premium payment.

Your Employer's Responsibilities: Your Employer must notify the qualified beneficiary, in writing, of: (a) his or her right to continue this Policy's group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Your Employer must provide the qualified beneficiary with written notice of the necessary benefit information, premium information, enrollment forms and instructions within 14 days of: (a) the date a qualified beneficiary's group dental benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or (b) the date a qualified beneficiary notifies Your Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a dependent child.

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

Election of Continuation: To continue his or her group dental benefits, the qualified beneficiary must give Your Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from Your Employer as described above. And the qualified beneficiary must pay his or her first month's premium within 45 days by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Policy, or to the Employer if the Employer has contracted with the Policy to perform the administrative services. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

The subsequent premiums must be paid to Your Employer, by the qualified beneficiary, in advance, at the times and in the manner specified by Your Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group Policy on a regular basis. It includes any amount that Your Employer would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," Your Employer may require an additional charge of 2% of the total premium charge. If the qualified beneficiary fails to give Your Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

When Continuation Ends: A qualified beneficiary's continued group dental benefits end on the first of the following to occur:

a) 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 of the qualifying event;

b) with respect to a disabled qualified beneficiary who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date of the qualifying event; or (2) 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 a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act;

c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a dependent's eligibility, the end of the 36 month period which starts on the date of the qualifying event;

d) with respect to a dependent whose continuation is extended due to the Employees entitlement to Medicare, while the dependent is on continuation, the end of the 36 month period which starts on the date of the qualifying event;

e) the date Your Employer ceases to provide any group dental plan to any Employee;

f) the end of the period for which the last premium is made;

g) the date he or she becomes covered under any other group dental plan which does not contain any pre-existing condition exclusion or limitation affecting him or her;

h) the date he or she becomes entitled to Medicare.

Small Employer Group

Applies to Members who are covered under a Policy between Us and a California small employer group with two (2) through nineteen (19) eligible employees.

You are eligible if You are a permanent employee who is actively engaged on a full-time basis in the conduct of the business of the small employer with a normal workweek of at least 30 hours, at the small employer regular places of business, and have met any statutorily authorized applicable waiting period requirements. It also includes any eligible employee who obtains coverage through a guaranteed association. This does not include employees who work on a part-time, temporary, or substitute basis.

Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(1) they otherwise meet the definition of an eligible employees except for the number of hours worked; (2) the employer offers the employee health coverage under a health benefit plan; (3) all similarly situated individuals are offered coverage under the health benefit plan; and (4) the employee must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter.

In order to receive CAL-COBRA benefits for yourself and/or Dependent(s), You or Dependent(s) must provide written notice to Us within sixty (60) days of the qualifying events, except if coverage terminates due to a reduction of employee work hours or termination of your employment. If Your coverage and/or coverage for Dependents will terminate due to a reduction of Your work hours or termination of Your employment, Your employer must notify Us within 30 days of the qualifying event. Notice will be sent to the last known address.

If you or Dependent(s) do not notify MDC within sixty (60) days of the qualifying event(s), You and Dependents(s) will not receive Cal-COBRA benefits. Dependents may also be disqualified from receiving Cal-COBRA benefits if your employer does not provide Us with notification as required by law and summarized in the Policy.

Within fourteen (14) days of receiving notification of a qualifying event, We will mail Cal-COBRA information package to the last known address of the Dependent. The package will contain premium information, enrollment forms and the disclosures necessary to formally elect Cal-COBRA continuation benefits and will be sent to the Dependents last known address.

If you and/or Dependent(s) are eligible for extended continuation coverage for twenty-nine (29) months as a result of a disability, You and/or Dependent(s) must notify Us within thirty (30) days of a determination that the Member is no longer disabled.

B425.0701

Option B

Family Medical Leave Of Absence (FMLA)

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

B425.0081

Option B

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's 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.

B425.0083

Option B

DENTAL BENEFITS

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

B425.0084

Option B

How to Contact Us

Our customer service associates can assist You with benefit coverage questions, resolving problems, selecting or changing a Dentist. A customer service associate can be reached toll free Monday through Friday at 1-888-273-3330 from 8:00 am to 8:00 pm, Pacific Standard Time. An automated service is also provided after hours for eligibility verification.

B425.1030

Option B

Managed Dental Care

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

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

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

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

B425.1039

Option B

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Schedule of Benefits section of this Evidence of Coverage. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a Patient Charge. Services specifically excluded from this coverage are listed in the section titled Exclusions in the Schedule of Benefits. Please read this section carefully. Dental services performed by a Non-Contracted Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Dental Services.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF DENTIST DENTAL CARE MAY BE OBTAINED.

B425.0703

Option B

Choice of Dentists

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

B425.0088

Option B

Changes in Dentist Participation

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

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

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

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

- Arrange for completion of the services by the original Dentist; or
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service.

B425.0089

Option B

Refusal of Recommended Treatment

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

B425.0090

Option B

Specialty Referrals

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

In order for specialty services to be covered by this Policy, the referral policy guidelines stated below must be followed:

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a Contracted Specialist is required, the PCD must complete the specialty referral request form. At this point, the following options are available:

  (a) The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to Us. We will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Contracted Specialist to schedule an appointment.

(b) The PCD may determine that the direct referral to the Contracted Specialist fits the referral policy guidelines. If so, the PCD will complete the specialty referral request form and provide this form to the Member and the Contracted Specialist. We will retrospectively review the direct referral upon receipt of the Contracted Specialist's claim, once the Contracted Specialist's procedures or services have been completed.

If the PCD's request for specialty referral is denied (an Adverse Determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. Refer to the Grievance Process section for additional information.

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

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

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

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

B425.0091

Option B

Facilities

MDC PCD's available under the Policy Contract are listed in the Network General Dentist booklet. MDC's PCD offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if You cannot keep Your scheduled appointment, You must notify Your PCD at least 24 hours in advance or You will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet. Broken appointment fees will be waived in exigent circumstances (e.g., emergency hospitalization of Member).

You may contact MDC's Member Services Department at 1-800-273-3330 to request the Network General Dentist booklet.

B425.1040

Option B

Telehealth

MDC shall provide coverage for health care services appropriately delivered through telehealth on the same basis and to the same extent that the Member has coverage for the same service through in-person diagnosis, consultation, or treatment.

B425.1223

Option B

Emergency Dental Services

The MDC Network also provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. You should contact Your selected PCD, who will arrange for such care. If You are not able to reach Your PCD in an emergency during normal business hours, You must call MDC's Member Services Department for instructions. If You are not able to reach Your PCD in an emergency after normal business hours, You may seek Emergency Dental Services from any Dentist. MDC will reimburse You for the cost of the Emergency Dental Services less any Patient Charge which may apply. You should present a statement from the treating Dentist. You must file a claim within 180 days of service. This should be submitted to the address listed on page 1.

B425.1224

Option B

Out-of-Area Emergency Dental Services

If You are out of the area, and Emergency Dental Services are required, You should seek palliative treatment from a Dentist. You must file a claim within 180 days of service. You must present a detailed statement from the treating Dentist, which lists the services provided. MDC will reimburse you within 30 days for any covered Emergency Dental Services, less applicable Patient Charges, up to $50 per incident. This paperwork should be submitted to the address listed on page 1.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of Your condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if You are requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating Dentist, acting within the scope of the Dentist's practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on Your health.

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

- Appropriate for Your dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for You at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Contracted Dentists are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how You may obtain urgent or emergency care, including how to contact another Dentist who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the Contracted Dentist does not answer and You have an emergency, You may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any Dentist.

Telephone triage or screening services are to be provided in a timely manner appropriate for Your condition. During normal business hours, the waiting time for You to speak by telephone with a knowledgeable and competent customer service representative regarding Your questions and concerns will not exceed 10 minutes.

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

B425.1031

Continuity of Care - Terminated Dentist

The Member may request for the continuation of covered services to be rendered by a terminated Contracted Dentist when the Member is undergoing treatment from a terminated Dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current Members or 180 days from the effective date for newly covered Members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Contracted Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members.

This provision does not apply to Contracted Dentists who voluntarily leave the plan. The Member must make the request in writing and send to:

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. The terminating Dentist must accept the contracted rate for that Member's treatment and agree not to seek payment from the Member for any amounts for which the Member would not be responsible if the Dentist were still in the network. The approval of the request to continue Member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating Dentist or Member wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated Dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

B425.1257

Option B

Continuity of Care - Non-Contracted Dentist

The Member, including a newly covered Member, may request for the continuation of covered services to be rendered by the Non-Contracted Dentist when the Member is undergoing treatment from the Non-Contracted Dentist for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Contracted Dentist's Agreement or 12 months from the Effective Date of coverage for newly covered Members. The Member must make the request in writing and send to:

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the Member's dental records from the Member's Dentist in order to evaluate the request. The Dental Director (or his/her designee) will determine if the Member is eligible for continuation of care under this Policy and the California Knox-Keene Act.

The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by Policy; and
3. The potential clinical effect that a change of Dentist would have on the Member's treatment.

B425.1258

Option B

Extended Dental Benefits

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

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

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

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

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

B425.0093

COORDINATION OF BENEFITS (COB)

A Member may have dental coverage 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 an Employee is primary.
- A plan that provides coverage for an active Employee 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 We are primary, benefits are determined as if no other plan exists.

B425.0096

Option B

Coordination with a Pre-Paid Dental Plan

A Member may also be covered under another pre-paid dental plan where they pay a fixed payment amount for each covered service. When the PCD participates under both pre-paid plans, the Member will never be responsible for more than the Patient Charge.

For Contracted Specialists' services, when this Policy is secondary, any payment made by the primary carrier is credited against the Patient Charge. In many cases the Member will have no out-of-pocket expenses.

B425.0097

Option B

Coordination with a PPO Dental Plan

When a Member is covered by this Policy and a fee-for-service plan, the following rules will apply:

- For PCD services: If this Policy is the primary plan, the PCD submits a claim to the secondary plan for the Patient Charge amount. Any payment made by the secondary carrier must be deducted from the Member's Patient Charge.
- For PCD services: If this Policy is the secondary plan, the PCD submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the Patient Charge, reducing the Member's out-of-pocket expense.
- For Contracted Specialist services: If this Policy is the primary plan, benefits are paid as usual.
- For Contracted Specialist services: If this Policy is the secondary plan, any payment made by the primary carrier is credited against the Patient Charge, reducing the Member's out-of-pocket expense.

B425.0098

Our Right to Certain Information

In order to coordinate benefits, We need certain information. A Member must supply Us with as much information as he or she can. If he or she can't give Us all the information needed, We have the right to request this information from any source. If another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information, We can't be held liable for such action except as required by law.

When payments that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

B425.0099

GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison ("QCL") who processes the grievances. The QCL can be contacted at 1-800-273-3330 or by mail to P.O. Box 25256, Lehigh Valley, PA 18002-5256. The QLC hours are from 8:00 a.m. to 5:00 p.m. Pacific Time. Grievances may also be submitted on Our website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

- Administrative Services: financial, accounting, procedural matters, coverage information such as effective dates, explanations of policy and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.
- Health Services: quality of care, access, availability, standards of care, appeal of denied second opinion requests, appeals of Specialty Referral decisions, professional and ethical considerations.

A grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding MDC's operation, including but not limited, to Policy administration, denial of access to a specialty referral as services are covered at the general Dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for the lack of medical necessity will be handled by the grievance process. Where MDC cannot distinguish between an inquiry and a grievance, it shall be considered a grievance.

A grievance and a complaint are one and the same.

Coverage dispute means that a Member is not provided a covered service as a Policy benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the customer services representative documents the call and works with the Member to resolve the issue. If the issue is as an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the customer services department. All other issues that are grievances will be documented on a grievance form by the customer services representative on behalf of the Member and the grievance form will be forwarded to the Quality of Care Liaison or Designee (QCL). The Member may be sent a grievance form to complete, if requested.

   When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work with the QCL and provide accommodation, according to MDC guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by MDC. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.

3. Members may file a grievance up to 180 calendar days following any incident or action that is the subject of the dissatisfaction. In the case of a grievance alleging that the Member's coverage has been or will be improperly cancelled, rescinded, or not renewed, the 180 days begins on the date indicated on the Notice of Cancellation, Rescission, or Nonrenewal.

4. No later than five (5) calendar days after receipt of the grievance, or three (3) calendar days for grievances received via the MDC website, an acknowledgment letter is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL that a review is taking place and the grievance will be responded to within 30 days from the date of MDC's receipt of the grievance in a resolution letter.

5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the Dentist or office personnel. MDC may arrange a second opinion, if appropriate.

6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 calendar days from the date of MDC's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution.

   The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his/her review of available documentation by initialing a copy of the resolution letter.

   The resolution letter to the Member will detail in a clear, concise manner the reasons for MDC's response. For grievances involving the delay, denial or modification of dental care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If MDC, or one of its clinical reviewers, issues a determination delaying, denying or modifying dental care services based in whole or in part on a finding that the proposed dental care services are not a covered benefit under the Policy that applies to the Member, the letter shall clearly specify the provisions in the Policy that exclude that coverage. In the event that an MDC grievance involves the delay, modification or denial of a covered service due to medical necessity, the resolution letter will include an IMR application and a Department of Managed Health Care addressed envelope.

B425.1260

Option B

7. Within thirty (30) calendar days following receipt of a resolution letter, a Member, or Member's Designee, may also request voluntary mediation with MDC prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a Member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care. In order to initiate mediation, the Member or the Member's Designee and MDC shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

   Following the use of the voluntary mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Dentist.

8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.

9. 9.Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) calendar days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function; for any case involving cancellation, rescission, or nonrenewal of coverage; or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.

10. MDC shall keep all copies of grievances, and the responses to grievances, for a period of five years.

11. MDC's Secretary, who is an officer of the plan, or designee, has primary responsibility for MDC's grievance system.

12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by MDC and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.

13. MDC asserts that there is no discrimination against a Member (including cancellation of the contract) solely on the grounds that the Member filed a complaint.

    The Department of Managed Health Care may contact MDC's Quality Management Staff regarding urgent grievances every business day from 8:00 am to 5:00 pm by calling 1-800-273-3330. For urgent grievances received from the Department of Managed Health Care during business hours, MDC will respond within 30 minutes. For urgent grievances after business hours, The Department of Managed Health Care should contact MDC's staff in the following order:

14. Dental Director/Plan Officer Responsible for Grievances at 1-310-908-1917, Quality of Care Liaison at 1-818-437-4177, and President at 1-207-210-8727. For urgent grievance calls received after hours, the above listed personnel will respond to the Department of Managed Health Care within one (1) hour after initial contact. Within one (1) business day of receipt of the Department of Managed Health Care's notice of acceptance of a proper complaint related to the cancellation, rescission, or nonrenewal of a Member's coverage, MDC shall respond and provide the Department of Managed Health Care with a copy of all information MDC used to makes its termination of coverage determination and all other relevant information necessary for the Department of Managed Health Care's review.

Grievances Requiring Expedited Review

MDC will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but are not limited to, procedures administered in a hospital, Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Policy.

MDC shall also conduct expedited review of grievances concerning the cancellation, rescission, or nonrenewal of coverage.

When MDC has notice of a grievance requiring expedited review, the grievance process requires MDC to immediately inform Members in writing of their right to notify the Department of Managed Health Care of the grievance. MDC also will provide Members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. MDC shall consider the Member's medical condition when determining the response time for an expedited grievance.

If the Member files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, MDC shall continue to provide coverage to the Member pursuant to the terms of the Member's Policy while the grievance is pending with MDC and/or the Department of Managed Health Care.

The following grievance disclosure will be on all Member correspondence:

Disclosure:

With respect to certain actions that impact You and Your coverage, Managed Dental Care or Your Employer will provide You with notice:

- When premium has not been paid and Your coverage is in force due solely to the Policy's Grace Period;
- When this Policy or Your coverage under this Policy is rescinded due to certain contractual provisions; or
- When this Policy is terminated for any other reason as may be allowed by the Policy.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance

involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

You may also access grievance forms at Managed Dental Care's website at **www.manageddentalcare.net.** Click on the "GRIEVANCE FORM" Portal box or may be obtained by contacting MDC's Customer Care Team at (800) 273-3330.

Note: Free language assistance services are available for You and Your dependents to assist with Your dental needs. Please contact Managed Dental Care's Member Services Department at 1-800-273-3330, Your assigned network general dentist or Your network specialist (for Managed Dental Care's approved specialty care) if English is not Your or Your dependents preferred spoken or written language.

Nota: Los servicios gratuitos de ayuda con el idioma estan disponibles para usted y sus dependientes para ayudarle con sus necesidades dentales. Si el inglis no es el idioma preferido de usted o sus dependientes, por favor comunmquese a nuestro Departamento de Servicios para Miembros al 1-800-273-3330, su dentista general de red asignada o su especialista de red (para una atencisn especializada de Managed Dental Care).

B425.1226

Option B

Covered Services

MDC covers diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, fixed prosthodontics, oral surgery, orthodontics and adjunctive general as well as specialist and Emergency Dental Services. Covered services will be provided as necessary for a Member's dental health consistent with professionally recognized standards of practice, subject to the limitations and exclusions described in connection with each category of covered services.

Covered services include:

DIAGNOSTIC

- Clinical Oral Evaluations
- Radiographs (X-rays)
- Tests and Examinations

* A complete list of covered diagnostic services is listed in the Schedule of Benefits.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed in the Schedule of Benefits.

RESTORATIVE

- Amalgam (silver fillings)
- Resin Based Composite (white fillings)
- Inlays
- Onlays
- Crowns
- Other Restorative Services

* A complete list of covered restorative services is listed in the Schedule of Benefits.

ENDODONTICS

- Pulp Capping
- Pulpotomy
- Endodontic Therapy (root canals)
- Endodontic Retreatment
- Apicoectomy/Periradicular Services

* A complete list of covered endodontic services is listed in the Schedule of Benefits.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed in the Schedule of Benefits.

PROSTHODONTICS
(Removable)

- Complete Dentures
- Partial Dentures
- Adjustments to Dentures
- Repairs
- Rebase
- Reline

* A complete list of covered prosthodontics (removable) services is listed in the Schedule of Benefits.

PROSTHODONTICS
(Fixed)

- Fixed Partial Denture Pontics
- Fixed Partial Denture Retainers - Crowns

* A complete list of covered prosthodontics (fixed) services is listed in the Schedule of Benefits.
Note: Treatment which requires the services of a Prosthodontist are not covered.

ORAL SURGERY

- Surgical Extractions
- Other Surgical Procedures
- Alveoloplasty
- Surgical Excision of Intra-Osseous Lesions
- Surgical Incision

* A complete list of covered oral surgery services is listed in the Schedule of Benefits.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed in the Schedule of Benefits.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed in the Schedule of Benefits.

A list of the services covered by this Policy, including Patient Charges is provided in the section Schedule of Benefits.

Exclusions and limitations will apply to some of the services. Refer to the Benefit Limitations, Additional Conditions and Exclusions sections of the Schedule of Benefits.

B425.1227

Option B

DEFINITIONS

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

B425.0712

Option B

Act: This term means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

B425.0713

Option B

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

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

B425.0102

Option B

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

B425.0103

Option B

Code: This term means the California Health and Safety Code.

B425.0714

Option B

Combined Evidence of Coverage and Disclosure Form: This term means this booklet issued to You, which summarizes the essential terms of this Policy.

B425.0724

Option B

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

B425.0105

Option B

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

B425.0106

Option B

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

B425.0107

Option B

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

B425.0715

Option B

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

B425.0717

Option B

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

B425.0719

Option B

Emergency Dental Service: This term means services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort or to prevent the imminent loss of teeth.

B425.0113

Option B

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

B425.0720

Option B

Full-time: This term means:

You are not a Part-time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 30 hours per week) at:

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

B425.0116

Option B

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

B425.0118

Option B

Network: This term means The Managed Dental Care network.

B425.0120

Option B

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

B425.0122

Option B

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

B425.0123

Option B

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

B425.0721

Option B

Policyholder: This term means an Employer that is offering benefits to a Member under this Policy.

B425.0125

Option B

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

B425.0126

Option B

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

B425.0128

Option B

Qualifying Event: This term means a specific occurrence that changes a Member's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental Policy; 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 Employer's rules.

B425.0130

Option B

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

B425.0131

Option B

Sensitive Services: This term means covered services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

B425.1225

Option B

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, state law or local law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B425.1050

Option B

We, Us, Our and MDC: These terms mean Managed Dental Care of California.

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

B425.0723

Option B

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 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 and Qualified Domestic Relations 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.

B425.0167

Option B

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 dental or medical 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 professional 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.

B425.0168

Option B

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017
1-800-273-3330

GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Policy, as well as the Patient Charges, Benefit Limitations, Additional Conditions and the Exclusions. Please read the entire Certificate of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

B425.1259

Option B

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - U60 M

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

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

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

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

B425.1112

Option B

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN U60 M

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

CDT CODE	COVERED DENTAL PROCEDURES	PATIENT CHARGE
D0100 - D0999	**DIAGNOSTICS**	
D0999	Office visit during regular hours, general dentist only	$5.00
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
D1000 - D1999	**PREVENTIVE**	
D1110	Prophylaxis - adult, for the first two services in any 12-month period	$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period	$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period	$60.00
D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period	$0.00

D1206	Topical fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	$0.00
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period	$20.00
D1310	Nutritional instruction for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth (molars)	$0.00
D9999	Sealant - per tooth (non-molars)	$35.00
D1510	Space maintainer - fixed - unilateral	$0.00
D1515	Space maintainer - fixed - bilateral	$0.00
D1525	Space maintainer - removable - bilateral	$0.00
D1550	Re-cementation of fixed space maintainer	$0.00
D1555	Removal of fixed space maintainer	$0.00

D2000 - D2999 RESTORATIVE

D2140	Amalgam - 1 surface, primary or permanent	$0.00
D2150	Amalgam - 2 surfaces, primary or permanent	$0.00
D2160	Amalgam - 3 surfaces, primary or permanent	$0.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$0.00
D2330	Resin-based composite - 1 surface, anterior	$0.00
D2331	Resin-based composite - 2 surfaces, anterior	$0.00
D2332	Resin-based composite - 3 surfaces, anterior	$0.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$0.00
D2390	Resin-based composite crown, anterior	$0.00
D2391	Resin-based composite - 1 surface, posterior	$0.00
D2392	Resin-based composite - 2 surfaces, posterior	$0.00
D2393	Resin-based composite - 3 or more surfaces, posterior	$0.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$0.00
D2510	Inlay - metallic - 1 surface	$60.00
D2520	Inlay - metallic - 2 surfaces	$75.00
D2530	Inlay - metallic - 3 or more surfaces	$75.00
D2542	Onlay - metallic - 2 surfaces	$80.00
D2543	Onlay - metallic - 3 surface	$80.00
D2544	Onlay - metallic - 4 or more surfaces	$80.00
D2610	Inlay - porcelain/ceramic - 1 surface	$60.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$75.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$75.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$80.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$80.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$80.00
D2740	Crown - porcelain/ceramic substrate	$100.00
D2750	Crown - porcelain fused to high noble metal	$95.00
D2751	Crown - porcelain fused to predominantly base metal	$95.00
D2752	Crown - porcelain fused to noble metal	$95.00
D2780	Crown - 3/4 cast high noble metal	$85.00
D2781	Crown - 3/4 cast predominantly base metal	$85.00
D2782	Crown - 3/4 cast noble metal	$85.00
D2783	Crown - 3/4 porcelain/ceramic	$85.00
D2790	Crown - full cast high noble metal	$95.00
D2791	Crown - full cast predominantly base metal	$95.00
D2792	Crown - full cast noble metal	$95.00
D2794	Crown - titanium	$95.00
D2910	Recement inlay, onlay, or partial coverage restoration	$0.00

D2915	Recement cast or prefabricated post and core	$0.00
D2920	Recement crown	$0.00
D2930	Prefabricated stainless steel crown - primary tooth	$10.00
D2931	Prefabricated stainless steel crown - permanent tooth	$10.00
D2932	Prefabricated resin crown	$20.00
D2933	Prefabricated stainless steel crown with resin window	$20.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$20.00
D2940	Sedative filling	$0.00
D2950	Core buildup, including any pins	$20.00
D2951	Pin retention - per tooth, in addition to restoration	$0.00
D2952	Post & core in addition to crown, indirectly fabricated	$30.00
D2953	Each additional indirectly fabricated post - same tooth	$10.00
D2954	Prefabricated post and core in addition to crown	$25.00
D2957	Each additional prefabricated post - same tooth	$8.00
D2960	Labial veneer (resin laminate) - chairside	$40.00
D2970	Temporary crown (fractured tooth)	$15.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$125.00

D3000 - D3999 ENDODONTICS

D3110	Pulp cap - direct (excluding restoration)	$0.00
D3120	Pulp cap - indirect (excluding restoration)	$0.00
D3220	Therapeutic pulpotomy (excluding final restoration) - Removal of pulp coronal to the dentinocemental junction and application of medicament	$10.00
D3221	Pulpal debridement, primary and permanent teeth	$10.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$10.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$15.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$15.00
D3310	Root canal, anterior (excluding final restoration)	$70.00
D3320	Root canal, bicuspid (excluding final restoration)	$80.00
D3330	Root canal, molar (excluding final restoration)	$140.00
D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$70.00
D3333	Internal root repair or perforation defects	$40.00
D3346	Retreatment of previous root canal therapy - anterior	$80.00
D3347	Retreatment of previous root canal therapy - bicuspid	$95.00
D3348	Retreatment of previous root canal therapy - molar	$150.00
D3410	Apicoectomy/periradicular surgery - anterior	$90.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$95.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$100.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$40.00
D3430	Retrograde filling - per root	$15.00
D3950	Canal preparation and fitting of preformed dowel or post	$20.00

D4000 - D4999 PERIODONTICS

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$60.00

D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$20.00
D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$105.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$35.00
D4249	Clinical crown lengthening - hard tissue	$85.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$155.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$95.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$100.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$110.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$120.00
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$25.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$15.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$15.00
D4910	Periodontal maintenance, for the first two services in any 12-month period	$15.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$0.00
D4999	Periodontal maintenance, for each additional service in same 12-month period	$60.00

D5000 - D5999 PROSTHODONTICS - REMOVABLE

D5110	Complete denture - maxillary	$110.00
D5120	Complete denture - mandibular	$110.00
D5130	Immediate denture - maxillary	$110.00
D5140	Immediate denture - mandibular	$110.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$90.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$90.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$130.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$130.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$140.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$140.00
D5410	Adjust complete denture - maxillary	$5.00
D5411	Adjust complete denture - mandibular	$5.00
D5421	Adjust partial denture - maxillary	$5.00
D5422	Adjust partial denture - mandibular	$5.00
D5510	Repair broken complete denture base	$0.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$0.00
D5610	Repair resin denture base	$0.00
D5620	Repair cast framework	$0.00

D5630	Repair or replace broken clasp	$0.00
D5640	Replace broken teeth - per tooth	$0.00
D5650	Add tooth to existing partial denture	$0.00
D5660	Add clasp to existing partial denture	$0.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$0.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$0.00
D5710	Rebase complete maxillary denture	$0.00
D5711	Rebase complete mandibular denture	$0.00
D5720	Rebase maxillary partial denture	$0.00
D5721	Rebase mandibular partial denture	$0.00
D5730	Reline complete maxillary denture (chairside)	$0.00
D5731	Reline complete mandibular denture (chairside)	$0.00
D5740	Reline maxillary partial denture (chairside)	$0.00
D5741	Reline mandibular partial denture (chairside)	$0.00
D5750	Reline complete maxillary denture (laboratory)	$0.00
D5751	Reline complete mandibular denture (laboratory)	$0.00
D5760	Reline maxillary partial denture (laboratory)	$0.00
D5761	Reline mandibular partial denture (laboratory)	$0.00
D5820	Interim partial denture (maxillary)	$45.00
D5821	Interim partial denture (mandibular)	$45.00
D5850	Tissue conditioning, maxillary	$0.00
D5851	Tissue conditioning, mandibular	$0.00

D6200 - D6999 PROSTHODONTICS - FIXED

D6210	Pontic - cast high noble metal	$90.00
D6211	Pontic - cast predomniantly base metal	$90.00
D6212	Pontic - cast noble metal	$90.00
D6214	Pontic - titanium	$90.00
D6240	Pontic - porcelain fused to high noble metal	$90.00
D6241	Pontic - porcelain fused to predominantly base metal	$90.00
D6242	Pontic - porcelain fused to noble metal	$90.00
D6245	Pontic - porcelain/ceramic	$90.00
D6600	Inlay - porcelain/ceramic, - 2 surface	$75.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$75.00
D6602	Inlay - cast high noble metal, - 2 surfaces	$75.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces	$75.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$75.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$75.00
D6606	Inlay - cast noble metal, 2 surfaces	$75.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$75.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$80.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$80.00
D6610	Onlay - cast high noble metal, 2 surfaces	$80.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	$80.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$80.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$80.00
D6614	Onlay - cast noble metal, 2 surfaces	$80.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$80.00
D6624	Inlay - titanium	$75.00
D6634	Onlay - titanium	$75.00
D6740	Crown - porcelain/ceramic	$100.00
D6750	Crown - porcelain fused to high noble metal	$95.00

D6751	Crown - porcelain fused to predominantly base metal	$95.00
D6752	Crown - porcelain fused to noble metal	$95.00
D6780	Crown - 3/4 cast high noble metal	$85.00
D6781	Crown - 3/4 cast predominantly base metal	$85.00
D6782	Crown - 3/4 cast noble metal	$85.00
D6783	Crown - 3/4 porcelain/ceramic	$85.00
D6790	Crown - full cast high noble metal	$95.00
D6791	Crown - full cast predominantly base metal	$95.00
D6792	Crown - full cast noble metal	$95.00
D6794	Crown - titanium	$95.00
D6930	Recement fixed partial denture	$0.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$30.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$25.00
D6973	Core buildup for retainer, including any pins	$20.00
D6976	Each additional cast post - same tooth	$10.00
D6977	Each additional prefabricated post - same tooth	$8.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment	$125.00

D7000 - D7999	**ORAL AND MAXILLOFACIAL SURGERY**	
D7111	Extraction, coronal remnants - deciduous tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$35.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$70.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$85.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$40.00
D7261	Primary closure of a sinus perforation	$250.00
D7280	Surgical access of an unerupted tooth	$90.00
D7283	Placement of device to facilitate eruption of impacted tooth	$35.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$45.00
D7286	Biopsy of oral tissue - soft	$40.00
D7288	Brush biopsy - transepithelial sample collection	$65.00
D7310	Alveoplasty in conjunction with extractions - 4 or more Teeth or tooth spaces, per quadrant	$35.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$16.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$45.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	$30.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$60.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$110.00
D7471	Removal of lateral exostosis (maxilla or mandible)	$75.00
D7472	Removal of torus palatinus	$75.00

D7473	Removal of torus mandibularis	$75.00
D7510	Incision and drainage of abscess - intraoral soft tissue	$25.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$30.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$60.00
D7963	Frenuloplasty	$100.00

D8000 - D8999 ORTHODONTICS

D8070	Comprehensive orthodontic treatment of the transitional dentition	$1500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1500.00
D8090	Comprehensive orthodontic treatment of the adult dentition	$2800.00
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention	$400.00

D9000 - D9999 ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$0.00
D9120	Fixed partial denture sectioning	$15.00
D9215	Local anesthesia	$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes	$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	$75.00
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$30.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
D9951	Occlusal adjustment - limited	$0.00
D9971	Odontoplasty, 1-2 teeth	$10.00
D9972	External bleaching - per arch	$165.00
	Broken Appointment	$25.00

Option B

PLAN U60 M

B425.1086

Option B

BENEFIT LIMITATIONS

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

NOTICE: Any benefit that includes an age restricted limitation will be subject to an exception based on medical necessity.

B425.1017

Option B

General

- Emergency Dental Services when more than fifty (50) miles from the PCD office: Limited to a $50.00 reimbursement per incident.
- Emergency Dental Services when provided by a Dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us: Limited to the benefit for palliative treatment (D9110) only.

B425.0142

Option B

Diagnostic

- Office visit Patient Charges that are the Member's responsibility after the group Policy has been in effect for three full years, will be paid to the PCD by Us.
- One intraoral complete series of radiographic images and one panoramic radiographic image: Limited to 1 each in 36 months.
- Bitewing radiographic images: Limited to 2 sets in 12 months.
- Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Limited to 1 in 24 months for persons age 40 or older.

B425.1087

Option B

Preventive

- Prophylaxis (D1110 or D1120) or periodontal maintenance (D4910): Limited to 2 in 12 months. One of the covered periodontal maintenance may be performed by a periodontist Contracted Specialist if done within 3 to 6 months following completion of approved periodontal scaling and root planing or osseous surgery by a periodontist Contracted Specialist. Members are eligible to receive 2 additional prophylaxes or periodontal maintenance in the same 12 months at the Patient Charge of D1999 (for prophylaxes) or D4999 (for periodontal maintenance).
- Fluoride treatment: Limited to 2 in 12 months. Members are eligible to receive 2 additional fluoride treatments in the same 12 months at the Patient Charge of D2999.
- Sealants or preventive resin restoration: Limited to permanent teeth, up to age 16, once per tooth in 36 months.

B425.1089

Option B

Crowns & Fixed Partial Dentures (Bridges)

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

B425.1090

Option B

Periodontics

- Gingival flap procedure or osseous surgery: Limited to 1 procedure per quadrant in 36 months.
- Tissue grafts: Limited to 1 procedure per tooth/site in 36 months.
- Periodontal scaling and root planing: Limited to once per quadrant in 12 months.

B425.1091

Option B

Prosthodontics

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

B425.0152

Option B

Oral and Maxillofacial Surgery

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

B425.0154

Option B

Orthodontics

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

- If a Member transfers to another orthodontist Contracted Specialist after authorized comprehensive orthodontic treatment has started under the Policy, the Member will be responsible for any additional costs associated with the change in orthodontist Contracted Specialist and subsequent treatment.
- The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility.
- The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention procedures are covered only following a course of comprehensive orthodontic treatment covered under the Policy.
- The Policy does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the Member's responsibility.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Policy provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the orthodontist Contracted Specialist's usual fee.

B425.1092

Option B

Adjunctive General Services

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

B425.1093

Option B

ADDITIONAL CONDITIONS

B425.0157

Option B

Alternative Procedure Policy

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

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

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

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

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

B425.0158

Option B

Exceptions to Alternative Procedure Policy

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

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

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

B425.0159

Option B

Second Opinion Consultation

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

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

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

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

B425.0727

Option B

Treatment in Progress

A Member may choose to have a Contracted Dentist complete an inlay, onlay, crown, fixed bridge, denture or root canal, or orthodontic treatment procedure which: (1) is listed in the Covered Dental Services and Patient Charges section; and (2) was started but not completed prior to the Member's eligibility to receive benefits under this Policy. The Member is responsible to identify, and transfer to, a Contracted Dentist willing to complete the procedure at the Patient Charge described in this section.

- Restorative Treatment: Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Policy, have a patient charge equal to 85% of the Contracted General Dentist's usual fee. (There is no additional charge for high noble metal.)

- Endodontic Treatment: Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are shown in the Covered Dental Services and Patient Charges section that were started but not completed prior to the Member's eligibility to receive benefits under this Policy may be covered if the Member identifies a Contracted General Dentist or Contracted Specialist who is willing to complete the procedure at a patient charge equal to 85% of Contracted Dentist's usual fee.

- Orthodontic Treatment: Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Policy may be covered if the Member identifies a Contracted Specialist who is willing to complete the treatment at a Patient Charge equal to 85% of the Contracted Specialist's usual fee. In this situation, the Patient Charge for retention services would also be equal to 85% of the Contracted Specialist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this Policy, the Patient Charge for orthodontic retention is equal to 85% of the Contracted Specialist's usual fee.

B425.1094

Option B

Treatment in Progress-Takeover Benefit for Orthodontic Treatment Provision

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

- The Member was covered by another dental HMO plan just prior to the Effective Date of the Policy and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior Dental Policy.
- This benefit applies to Members of new Policies only. It does not apply to Members of existing Policies and it does not apply to persons who become newly eligible under the Group after the Effective Date of this Policy.
- The Member has such orthodontic treatment in progress at the time the Policy becomes effective.
- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- The Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental HMO plan.
- We will only cover up to a total of 24 months of comprehensive orthodontic treatment.
- A "Treatment in Progress - Takeover Benefit for Orthodontic Treatment" form, completed in its entirety by the treating orthodontist, is submitted to Us within 6 months of the Effective Date of the Policy.

The benefit amount will be calculated based on: (a) the number of remaining months of comprehensive orthodontic treatment; and (b) the amount by which the Member's payment responsibility has increased as a result of the treating orthodontists raised fees, up to a maximum benefit of $500 per Member.

We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under this Policy is terminated.

The benefit will not apply if the comprehensive orthodontic treatment started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another orthodontist. The benefit does not apply to any other orthodontic services.

B425.1096

Option B

EXCLUSIONS

We will not pay benefits for:

- Treatment needed due to an on-the-job or job-related injury or a condition for which benefits are payable by Worker's Compensation, occupational disease law or similar laws, whether or not the Member claims his or her rights to such benefits.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
- Any histopathological examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatments or appliances requested, recommended or performed: (a) which in the opinion of the Contracted Specialist or Contracted General Dentist are not necessary for maintaining or improving the Member's dental health, or (b) which are solely for cosmetic purposes, except for bleaching.
- Precision attachments, stress breakers, magnetic retention or overdenture attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or is considered by the American Dental Association (ADA) to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis, or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
- Any Member request for specialist procedures or treatment which can be routinely provided by the PCD, or by a specialist without a direct referral from the PCD or a pre-authorization by Us.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits for such treatment.

- Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; (4) splint or stabilize teeth for periodontal reasons; or (5) improve cosmetic appearance, except for bleaching.

- Any procedure, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

- Dental procedures, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's selected and assigned PCD, unless previous written authorization was provided by Us.

- 2D cephalometric radiographic images except when performed as part of an orthodontic treatment plan and records for a covered course of orthodontic treatment.

- Treatment which requires the procedures of a prosthodontist.

- Treatment or Procedures which requires the services of a pediatric dentist Contracted Specialist, after the Member's 8th (eighth) birthday.

- Consultations for non-covered procedures.

- Any procedure or treatment not specifically listed in the Covered Dental Procedures and Patient Charges section.

- Any procedure associated with the placement or removal, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered procedures as a result of the presence of a dental implant.

- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Policy, except as described under Treatment in Progress Restorative Treatment. Inlays, onlays, crowns or fixed bridges are (a) considered to be started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken; and (b) completed when the denture is delivered to the Member.

- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Policy, except as described under Treatment in Progress - Endodontic Treatment. Root canal treatment is considered to be (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.

- Inlay, onlays, crowns, fixed bridges or dentures started by a Non-Contracted Dentist. Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. This exclusion will not apply to services that are started and which were covered under the Policy as Emergency Dental Services.

- Root canal treatment started by a Non-Contracted Dentist. Root canal treatment is considered to be started when the pulp chamber is opened. This exclusion will not apply to services that were started and which were covered under the Policy as Emergency Dental Services.
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under comprehensive orthodontic treatment or to correct or control harmful habits.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances lost or damaged.

B425.1098

Option B

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN U60	**Deductibles**	**Lifetime Maximums**	**Professional Services**			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Bitewings Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			No Charge	Prophylaxis - $0 - $60; Flouride - $0 - $20; Sealants - $0 - $35; Space Maintainers - $0	Amalgam - $0; Resin - $0; Crowns - $85 - $100; Inlays & Onlays - $60 - $80; Labial Veneer - $40; Miscellaneous Restorative Services - $0 - $125	Pulp Cap - $0; Pulpotomy - $10 - $15; Root Canals - $70 - $140; Retreatments - $80 - $150; Apicoectomy - First Root - $90 - $100; Each Additional Root - $40; Retrograde Filling - Per Root - $15; Canal Preparation - $20

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Cont.)	**Deductibles**	**Lifetime Maximums**	**Professional Services (Continued)**			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, Up To 16th Birthday, One Per Tooth In Any 3-Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

MDC U60 0308

B850.1076

Option B

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Continued)	**Professional Services (Continued)**				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Services (Continued)	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Crown Lengthening; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor Excision Of Bone Tissue	Comprehensive Treatment; Retention; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia General Anesthesia Intravenous Conscious Sedation/ Analgesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - $20 - $60; Gingival Flap Procedure - $35 - $105; Osseous Surgery - $95 - $155; Scaling & Root Planing - $15 - $25; Soft Tissue Graft - $100 - $120; Crown Lengthening - $85; Miscellaneous Periodontal Services $0 - $15	Complete Denture $110; Immediate Denture - $110; Rebase - $0; Interim Partial - $45; Partial Denture - $90 - $140; Reline - $0; Repair - $0; Tissue Conditioning - $0; Denture Adjustment - $5	Extractions - Coronal Total/ Remnants/ Erupted Exposed Root - $10; Surgical Removal - $35; Removal Of Impacted Tooth - $50 - $85; Alveoloplasty - $16 - $45; Removal of Cyst/ Tumor - $60 - $110; Excision Of Bone Tissue - $75; Surgical Incision - $25 - $30; Other Surgical Procedures - $35 -$90; Other Repair Procedures - $60 - $100;	To Age 18 - $1500; Over Age 18 - $2800; Retention - $400; Treatment Plan And Records - $250.00	Office Visit - $0 - $10; After Hours Office Visit - $50; Palliative Treatment - $0; Local Anesthesia - $0; General Anesthesia/ Conscious Sedation - $75 - $95; External Bleaching - $165; Miscellaneous Services - $0 - $34

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Continued)	**Professional Services (Continued)**				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations (Continued)	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/ Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

B850.1080

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDC U60 0308

B850.1078

Option B

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U60 (Cont.)	Outpatient Services	Hospitalization Service	Emergency Health Coverage		Ambulance Services	Prescription Drug Services
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to $50 Reimbursement Per Incident	Not Covered*	Not Covered*

U60 (Cont.)	Durable Medical Equipment	Mental Health Services	Chemical Dependency Services	Home Health Services	Other
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDC U60 0308

B850.1079

Important Notices

Employer-funded benefits - not insured by Guardian

This Member Guide explains the coverage your planholder offers. It explains the benefits available, as well as the requirements and limits of this coverage.

This is not insurance provided by Guardian. Instead, your planholder has engaged Guardian only to provide administrative services, such as processing claims. Your planholder's funds will be used to pay these claims. Your planholder is solely responsible and liable for the benefits available under this Plan.

You may not be covered by all of the options in this Member Guide

This Member Guide contains all the benefits and options that are available under this Plan. 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.

Guardian®

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

Dental insurance member guide

Welcome to Guardian!

We've been selected by your organization to provide group dental insurance. We'd like to welcome you to our company!

This is the member guide

This guide explains how this insurance coverage works and gives important details about the coverage.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-627-4200 **guardianlife.com**

Planholder: SAINT MARY'S COLLEGE OF CALIFORNIA

Plan Number: 00072651

B650.0004

TABLE OF CONTENTS

Option A

Guide basics

This Member Guide is part of a group insurance Plan

We've entered into an agreement with the Planholder listed on the first page to provide this insurance coverage. The details of the agreement are contained in the Policy we've issued to the Planholder. Check with your Planholder to determine if this coverage is available to you.

This Member Guide is part of the Policy we've issued to the Planholder. Although this is considered a certificate of insurance, we usually refer to this simply as the guide. This guide is important because it tells you how this insurance coverage works.

Unless we specifically say otherwise, when we mention "you" and "your" in this guide, we're referring to you, a member of the organization listed on the first page as the Planholder. Where we say "we" and "us", we're referring to The Guardian Life Insurance Company of America. We usually refer to ourselves simply as Guardian.

How this guide is organized

This guide has five sections. Here's what you'll find in each section:

- **Your benefits**
  This section explains the benefit options that are available to you. This section will help you understand the details of your coverage and how much we'll pay when you receive dental care.

- **Using your benefits**
  This is where you'll find how benefits are paid and how you or your dentist can submit a claim for benefits.

- **Member coverage & family coverage**
  Here's where we explain who's eligible for this coverage and what you need to do to obtain coverage. We also explain what can end your eligibility for coverage.

- **Other things you should know**
  You should review and understand these other items that are also important to your coverage.

- **Covered Services Guide**
  This may be a separate document but is considered part of this guide. It lists the different dental services covered by this guide and explains any limits or requirements you need to know.

B650.0005

Option A

Your benefits

This section explains the benefits available through this guide, including:

- Dental services that are covered
- How much we'll pay
- Any deductibles and benefit maximums

When we mention family and family members in this section, we're referring to family members who are covered by this guide.

This guide uses the term "benefit year". This is the 12-month period that begins on January 1st and ends on December 31st.

Covered dental services

There are many different dental services you can receive from your dentist. The services for which benefits are available are grouped into one of the categories listed below. These categories will help you understand what we'll pay, as well as any deductibles that must be met.

This list is a summary. For a detailed list of covered services, and the requirements or limits that apply to them, see the Covered Services Guide.

B650.0007

Option A

What we pay

Preventive services

- In-network dentist 100%
- Out of network dentist 100%

Option A

Basic services

- In-network dentist 80%
- Out of network dentist 80%

Option A

Major services

- In-network dentist 50%
- Out of network dentist 50%

Option A

Orthodontic care

- In-network dentist 50%
- Out of network dentist 50%

Option A

Using a network dentist can save you money

We have a network of dentists to help lower your dental expenses. Our network is called DentalGuard Preferred.

You can go to any dentist you choose, but you can save money by using a dentist in our network. As you can see in the **What we pay** table above, we usually pay a higher percentage of the dentist's fee when you use a dentist in our network.

Also, because dentists in our network will discount their fees for many services, any amount you're responsible for paying may be less if you go to a dentist in our network. This could mean lower out-of-pocket costs for you.

Some states allow dentists in our network to charge the full, undiscounted amount for dental services that aren't covered by this guide. This means if your dentist provides a service that isn't covered by this guide, you won't receive any benefits and you might not receive a discount.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice.

B650.0146

Option A

What happens when you use a dentist that isn't in our network

If you use a dentist that isn't in our network, the benefits we pay will be based on the lesser of:

- the dentist's fee
- the amount dentists in your local area typically charge for the same service

Your local area is the area represented by the first 3 digits of the zip code in which your dentist provided the service. The amount dentists typically charge for the same services means that 90% of the dentists charge this amount or less for the service. We determine this amount in accordance with Guardian's Reimbursement Schedule, which includes a combination of insurance market, third party and our own data.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice. If this happens, we'll use the average cost of the alternative treatment or service in your local area to determine the benefits available.

B650.0152

Option A

Deductibles

Option A

Annual deductible

- In-network dentist $50.00
- Out of network dentist $100.00

Option A

Must the deductible be met for preventive services?

- In-network dentist . . . . . No
- Out of network dentist . . . . . No

Option A

Must the deductible be met for basic services?

- In-network dentist . . . . . Yes
- Out of network dentist . . . . . Yes

Option A

Must the deductible be met for major services?

- In-network dentist . . . . . Yes
- Out of network dentist . . . . . Yes

Option A

The annual deductible is the amount you're responsible for paying for the dental services you receive during a benefit year before benefits will be available. The annual deductible is listed in the table above.

The annual deductible must be met by you and each of your family members separately. Benefits will be available to you once you've met this deductible. Benefits will be available to a family member when that family member has met this deductible.

When a total of 3 people in your family have each met the annual deductible, we'll consider everyone in the family to have met it.

Benefits for some dental services are available without any deductible having to be met. This is also listed in the table above.

Only dental expenses that are otherwise covered and that would be paid by this guide can be used to meet your deductible. In other words, only the amount in benefits that would be paid if there was no deductible will be applied to the deductible. You won't be reimbursed for any expenses that are applied to the deductible.

B650.0250

Option A

In-network vs. out of network
Any fees applied to the deductible when you use a DentalGuard Preferred dentist will also be applied to the deductible for services you receive from a dentist that isn't in our network. Similarly, any fees applied to the deductible when you use a dentist that isn't in our network will also be applied to the deductible for services you receive from a DentalGuard Preferred dentist.

B650.0288

Option A

Deductible(s) satisfied under a prior plan
If this Plan replaced a prior plan, we'll give you credit for any portion of the annual deductible that had already been met for the same benefit year. Documentation of the expenses applied to the prior plan's deductible will be required.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B650.0293

Option A

Benefit maximums

A benefit maximum is the most we'll pay for dental services received during a specific period of time, such as a benefit year or during your lifetime on this Plan. Once we've paid this amount, no additional benefits will be available for services received during that period.

B650.0300

Option A

Annual maximum

- In-network dentist $2,000.00
- Out of network dentist $2,000.00

Option A

Orthodontic lifetime maximum

- In-network dentist $1,500.00
- Out of network dentist $1,500.00

Option A

The annual maximum is the most we'll pay in benefits for dental services you receive during a benefit year. The annual maximum is listed in the table above.

This maximum applies to you and each of your family members separately. This means you each have an annual maximum in the amount listed in the table above.

B650.0386

Option A

Orthodontic care lifetime maximum

Orthodontic care has its own lifetime maximum. This is the most we'll pay in benefits for orthodontic care received during your lifetime on this Plan. The orthodontic care lifetime maximum is listed in the table above.

This maximum applies to each person that receives orthodontic care benefits separately. This means each person eligible to receive orthodontic care benefits has a lifetime maximum in the amount listed in the table above.

Benefits paid for orthodontic care will count toward the orthodontic care lifetime maximum, but not the annual maximum for other services listed above.

B650.0397

Option A

In-network vs. out of network
The maximum benefits available may depend on the type of dentist you use. This is listed in the above table.

Benefits paid for services received from a DentalGuard Preferred dentist will also count toward the maximum amount available for services received from a dentist that isn't in our network. Similarly, any benefits paid for services received from a dentist that isn't in our network will also count toward the maximum amount available for services you receive from a DentalGuard Preferred dentist.

B650.0428

Option A

Benefits paid under a prior plan
If this Plan replaced a prior plan, any benefits paid for dental services received during the same benefit year will be deducted from the annual maximum listed above. Documentation of benefits paid under the prior plan will be required.

Any benefits paid under a prior plan for orthodontic care will be deducted from this Plan's orthodontic care lifetime maximum.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

B650.0433

Option A

Waiting period if you enroll late

If you don't enroll for coverage within the time allowed benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

B650.0454

Option A

- Basic services . . . . . 6 months
- Major services . . . . . 12 months
- Orthodontic services . . . . . 24 months

The same waiting periods must be satisfied by each family member that's enrolled late.

The waiting periods listed above are in addition to any other waiting periods included under this Plan. This means the waiting periods for enrolling late will not begin until any other waiting period for the same dental service has been satisfied.

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

See the **You must enroll within the time allowed** section for more information.

B650.0455

Using your benefits

Timely access to care

California law requires dental plans to provide timely access to care. This means that there are limits on how long you have to wait to get dental appointments and telephone advice.

- Urgent appointments - You have the right to an appointment within 72 hours.
- Non-urgent appointments - You have the right to:
  - A non-urgent appointment within 36 business days
  - Preventive care appointments within 40 business days

The wait time standards don't apply if you're requesting a specific date and time.

Continuity of care

If your dentist leaves our network while you're receiving covered services for an acute condition, we'll consider the completion of those services for that condition as being performed by an in network dentist.

At your request, we can arrange for the completion of covered services by the terminated dentist for the remainder of the acute condition. An acute condition means a dental condition that involves a sudden onset of symptoms that requires prompt attention and that has a limited duration. A terminated dentist means a dentist whose contract to provide services is terminated or not renewed by us or one our contracting dental groups. You must be undergoing a course of treatment for an acute condition and your coverage under the policy must continue during the completion of covered services.

Paying your dentist

When you receive dental care, your dentist might submit your claim and wait to see what we pay before asking you to pay anything. Or your dentist could ask that you pay for the services at the time you receive them. Then, either you or your dentist can submit your claim for benefits under this Plan.

See the **What you should do when you have a claim** section for more information on how to send us your claim.

What you're responsible for paying

You're responsible for paying your dentist for any dental expenses that aren't covered by this guide. This includes any deductibles and any other amounts we don't pay. For example, if we pay 80% of a covered service, this means you must pay the other 20%. This is sometimes referred to as "coinsurance".

You're also responsible for paying any fees for services that exceed what's allowed by this guide.

If you use an in-network dentist, you don't need to pay any amounts that are over the discounted amount your dentist agreed to accept. See the **Using a network dentist can save you money** section for more information.

Pre-treatment review of proposed dental services

If you'd like to know how much we'll pay for a dental service before you receive it, we encourage you to have your dentist submit a pre-treatment review. We'll compare the services proposed to the benefits available under this guide and tell you how much we expect to pay. You'll then know how much of the dentist's fee you'll have to pay.

Although these reviews are completely optional, they're a good way to avoid surprises.

Please keep in mind, the amount we tell you we expect to pay is an estimate. The amount we'll pay when you receive the service can change because of factors such as the maximum benefits remaining, your dentist's participation in our network and you continuing to be covered under this Plan.

Your dentist can submit a pre-treatment review in the same way that a claim is submitted. If you have any questions on how to do this, contact your dentist or visit us at guardianlife.com.

Once you've received the proposed services, a claim will need to be submitted so we can pay any benefits available. See the **What you should do when you have a claim** section for more information.

What you should do when you have a claim

Your dentist might submit your claim for you. If your dentist doesn't submit your claim, you can do it yourself by following these simple steps:

Step 1 - Start your claim

When you have a claim, you'll need to complete a claim form. Part of the form will have to be filled out by your dentist. When it's complete, you or your dentist should send it to us.

You can print a claim form by going to guardianlife.com.

You can also call us at 800-541-7846 to request a claim form.

You can also write to us to tell us you have a claim. Our address for claims is:

Guardian
Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

If we don't send you a claim form within 15 days of when you asked for it, you can still submit your claim. To do so, mail us a copy of the dentist's bill. This should identify who you are and include the date(s) and details about the services received. Send this to the address listed above.

Step 2 - Submit your claim

If you're submitting a paper claim, the completed claim form should be mailed to:

Guardian
Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

Be sure to include all the information and copies of any documents the instructions indicate are necessary. The claim form and supporting documents are referred to as "proof of loss".

You or your dentist should submit your proof of loss as soon as you can, but you must submit it within 15 months of the date you received the dental services for which you're seeking benefits.

We'll only consider claims submitted after this 15 month period if you were legally incapacitated and unable to submit it within the time allowed.

What we'll do when we receive your claim

We'll review your claim to make sure it's complete

- We'll conduct a full and fair review of your claim.
- We'll complete our review of your claim within 30 days of receiving your proof of loss.

- In the event we need more time to consider your claim, which might be the case if we need more information, we can extend this review period by an additional 60 days. We'll notify you in writing if this happens and we'll explain the reason(s) more time is needed.
- If we need more information to consider your claim, we may request this information directly from your dentist. We may need to obtain X-rays, periodontal charting, narratives and other diagnostic information to consider your claim. Your dentist must provide us with the information we need to evaluate your treatment and determine the benefits payable.
- We may use the professional review of a dentist to determine the appropriate benefit for a dental service or course of treatment.
- If we need additional information from you, we'll let you know.

We'll determine if benefits are payable

- We'll make a decision within 30 days of our receiving the information needed to consider your claim.
- If benefits are payable, we'll pay the amount specified in this guide.
- If we deny any part of your claim, we'll provide a written explanation of the specific reason(s) your claim wasn't paid. We'll also include information on how you can appeal our decision.

When we'll pay

If we determine benefits are payable, they'll be paid promptly, and no more than 30 days from the date we receive the information needed to make the decision on your claim.

Who we'll pay

If an in-network dentist provided your dental services, we'll pay the benefits directly to your dentist.

If a dentist that isn't in our network provided your dental services, we'll pay the benefits to you unless you instruct us to pay your dentist directly.

If you're no longer living, we have the right to pay your benefits to one of the following, in the order listed:

- Your spouse
- Your children
- Your parents
- Your estate

If benefits are payable to your estate, and the amount is $1,000 or less, we can pay someone related to you by blood or marriage who we believe is entitled to the benefits. Any such payment will meet our obligations under this Plan.

B650.1131

Option A

What happens if your claim is denied

If we deny your claim or a part of your claim, we'll provide a written explanation within 30 days of our receiving the information we needed to make the decision. This explanation will include the specific reasons the claim was denied.

If we deny your claim because you or your dentist didn't reply to our requests for information, we'll provide a written explanation within 30 days of the date the information was due. This explanation will list the information you or your dentist were asked to submit.

We'll also provide instructions listing your rights to appeal your claim. These will explain the following:

- You'll need to submit a written appeal within 180 days of receiving our claims decision. The appeal should include any additional information or documentation you or your dentist think would be important for us to consider. Send your appeal to the address listed in the appeal instructions.
- We'll conduct a full and fair review of your appeal.
- We'll complete our review within 60 days of our receipt of your appeal.

- In the event we need more time to consider your appeal, which might happen if we need additional information, we can extend this review period by another 60 days. We'll let you know if additional time or information is needed.
- We'll let you know of our decision in writing. If we deny your appeal, we'll provide the specific reasons for the denial.

You should refer to the instructions included with any denial for more information on the appeals process.

What you can do if you have a complaint or grievance
If you have a complaint or grievance, you can call us at 800-541-7846 and we'll provide you with instructions on how to file your complaint or grievance.

You can also contact the California Department of Insurance:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)

Website: www.insurance.ca.gov/01-consumers/

Other things you should know about claims

Who pays first when you're covered by more than one plan
Because you and any family members covered by this Plan may have other dental coverage, we need to determine which plan is responsible for paying first. We coordinate benefits with other plans, so the total amount of benefits paid doesn't exceed the allowable amount for the services received.

This Plan will pay any benefits available for the covered services you receive before any other dental plan.

For covered services your spouse receives, the plan that will pay any benefits available first will be:
- Your spouse's plan if your spouse is covered as an active employee.
- The plan that's been in place the longest if the above rule doesn't apply.

For covered services your child receives, the plan that will pay any benefits available first will be:
- The plan of the parent whose birthday is earlier in the year.
- For a child whose parents are separated and not living together:
  - In an equal custody split, the plan of the parent whose birthday is earlier in the year.
  - The plan identified by any applicable court order.
  - If there isn't a court order that says which plan pays first, the dental services will be paid in the following order:
    - The plan of a biological parent with custody pays first.
    - The plan of a stepparent with custody pays second.
    - The plan of a biological parent without custody pays third.
    - The plan of a stepparent without custody pays fourth.

Coordinating benefits
When this Plan pays benefits first, we'll calculate the benefits payable as if you have no other dental coverage.

When another plan pays benefits first, the benefits available under this Plan will be calculated so that the total amount of benefits paid between all of your plans combined doesn't exceed the allowable amount for the services received. We also won't pay more in benefits than we'd pay if this Plan paid first.

A dentist that's in a network has agreed to charge a certain amount for specific dental services. These amounts are listed in what we call a fee schedule. We apply the following rules when determining the benefits available:

- When both plans use a fee schedule, the schedule allowing the higher fee will be used.
- When the plan that pays first is the only plan that uses a fee schedule, that plan's fee schedule will be used.
- When another plan pays first and doesn't use a fee schedule, the fee schedule for this Plan will be used.
- When neither plan uses a fee schedule, the highest allowable amount offered by either plan will be used.

Overpayments
If we paid more in benefits than this guide offers, you'll have to return the amount of the overpayment to us. We may ask you to send us the overpayment, or we might deduct the overpayment from future benefits.

Legal action
You can't bring a legal action under this Plan until 60 days after you've submitted proof of loss. You also can't bring a legal action more than three years from the time proof of loss is required, or the date we make a decision on your claim, whichever is later.

Examination
While we're reviewing your claim or appeal, we may require that you be examined by a medical or dental practitioner of our choice as often as reasonably necessary.

We'll pay for any examination we require.

Insurance fraud
We can terminate this coverage if you or your representative commits fraud with respect to a claim.

B650.1133

Option A

Member coverage

Who's eligible

To be eligible for coverage under the Plan, you must meet the following requirements:

You must be in an eligible class of members
Your Planholder may choose to offer coverage to all members or only to those in certain job classifications.

A job classification or class of members is a group of members that fit into the same category. For example, a Planholder could have one class for hourly employees and another class for salaried employees.

If only certain classes are eligible for coverage, you must be in one of these classes to obtain coverage. If you have any questions about your eligibility, please contact your Planholder.

You must meet the minimum number of working hours required
You need to be actively working and performing the regular duties of your job. You must be working the number of hours your Planholder requires for your class, and not less than 30 hours per week.

Eligible retirees don't need to meet this requirement.

You must wait to be eligible for coverage
Your Planholder has a waiting period that new members must meet before they can be eligible for this coverage. Your Planholder can tell you if you must meet a waiting period and how long it lasts.

B650.0473

Option A

How to get coverage

If you meet the eligibility rules listed above, you must also do the following to obtain coverage:

You must enroll within the time allowed
You must enroll within 31 days of the date you first become eligible for coverage.

You can also enroll when you have a qualifying life event
If you don't enroll within the time allowed, you can enroll within 31 days of a qualifying life event. This includes:

- Your coverage ending under another dental plan
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- Your loss of coverage under your spouse's dental plan
- An event required by state or federal law or specified by your Planholder's guidelines

What happens if you enroll late

If you don't enroll within the time allowed, you'll be able to enroll during the next open enrollment period.

Enrollment periods usually occur once every year. We agree with your Planholder on when open enrollment periods happen, and how long they last.

If you have any questions about the open enrollment periods or when you can enroll, please contact your Planholder.

You may have to satisfy a waiting period if you enroll late. See the **Waiting period if you enroll late** section for more information.

Your premium must be paid
We must receive the required premium for your coverage.

B650.0478

Option A

When your coverage begins

If you're eligible for coverage and have done what's required to obtain coverage, as explained under **How to get coverage,** your coverage begins at 12:01 AM EST on the first day you became eligible for coverage.

You must be actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on the date your coverage is scheduled to begin. If you don't meet this requirement, your coverage won't begin until you return to being actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder.

Your coverage may be scheduled to begin on or during one of the following:

- A holiday
- A vacation day
- A day you're not scheduled to work

If this happens, coverage will still begin on that same day if you were actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on your last regularly scheduled workday.

B650.0479

Option A

When your coverage ends

Your coverage will end at 11:59 PM EST on the earliest of the following:

- The last day of the month in which you're no longer eligible under this guide.
- The date this coverage is no longer available to the class of members to which you belong.
- The last day of the period or which the required premiums have been paid.
- The day you die.
- The day this Plan ends.

B650.0480

Option A

COBRA continuation rights
If your coverage ends, or a family member's coverage ends, you may be able to keep this coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA). If you have any questions, please contact your Planholder or visit us at guardianlife.com.

B650.0484

Option A

Family leave of absence - Family & Medical Leave Act (FMLA) & Uniformed Services Employment & Re-employment Rights Act (USERRA)
These options are available only if your Planholder is legally required to allow for a family leave of absence. You can confirm with your Planholder if these options are available.

If these options are available to you, you can keep this coverage when you take a leave of absence approved by your Planholder for one of the following reasons:

- To care for a seriously injured or ill spouse, child, or parent
- Within 12 months following the birth or adoption of a child
- Due to your own serious health condition
- To care for a spouse, child, parent or next of kin, who's your closest blood relative, that suffered a sickness or injury while on active duty in the US Armed Forces

You can keep this coverage while on leave for up to 12 weeks in any 12-month period. However, if the leave is to care for a family member who was injured or became ill while on active duty, as explained above, you'll be able to keep this coverage for up to 26 weeks of leave in a 12-month period.

If you take a family leave for any other reason during this same 12-month period, this will count toward the 26-week maximum.

Any subsequent leave to care for a service member will be limited to 12 weeks.

B650.0485

Option A

Family coverage

Who's eligible

The following family members are eligible for coverage:

- Your spouse, civil union partner or domestic partner

  A spouse is the person to whom you're legally married, your civil union partner, or your domestic partner.

  Your domestic partner is the person of the same or different sex with whom you live and share financial assets and obligations. Your domestic partner must be able to provide legal consent and can't be a blood relative. You and your domestic partner may not be married to, in a domestic partnership with, or legally separated from anyone else.

  Your domestic partnership must be registered with a state or local government registry.

  We won't require proof of registered domestic partnership that we wouldn't require of a marriage.

B650.0487

Option A

- Your child, who's
  - Under the age of 26

  Your child is one of the following:
  - Your biological child
  - Your stepchild
  - A child placed with you for adoption or foster care
  - A child for whom you've been appointed a legal guardian and who you claim as a dependent on your federal income taxes

  A child who's incapable of self-support because of mental, physical, or developmental disability may be able to keep this coverage past the maximum age. See the **Keeping this coverage for a child who reaches the age limit** section.

B650.0491

Option A

Family members that aren't eligible

- A family member who's on active duty in the armed forces.
- A child who's an eligible dependent of more than one member can be covered through only one member.
- A family member who's also eligible for coverage as a member under this Plan can't be covered more than once.

B650.1199

Option A

How to get coverage for your family

If your family member(s) are eligible, you must do the following to obtain coverage:

You must be enrolled
In order to enroll your family members, you must already be enrolled for coverage, or you must enroll yourself when you enroll them.

You must enroll your family members
You can enroll your eligible family members when they first become eligible.

You can enroll family members when there's a qualifying life event
You can also enroll an eligible family member within 31 days of a qualifying event. This includes:

- Your marriage or entrance into a domestic partnership
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- The death of your spouse
- The birth or adoption of your child or your assuming legal responsibility for a foster child
- Your spouse's loss of coverage under another dental plan
- Your spouse's loss of employment

Your biological children are automatically covered for the first 31 days following their birth. Your adopted children and foster children are automatically covered for the first 31 days from the date they are placed in your care.

You must enroll biological, adopted, and foster children and pay the required premium within this 31-day period or their coverage will end when the 31 days are over.

What happens if you enroll family members late
If you didn't enroll your eligible family members within the time allowed, you'll be able to enroll them during the next open enrollment period.

They may have to satisfy a waiting period because you enrolled them late. See the **Waiting period if you enroll late** section for more information.

The premium must be paid
We must receive the required premium for family coverage.

B650.0496

Option A

When family coverage begins

If you enrolled your family members when you enrolled yourself, their coverage begins at the same time your coverage begins. If you did not enroll your family members at the same time you enrolled yourself, their coverage will begin at 12:01 AM EST on the date you enroll them.

B650.0499

Option A

When family coverage ends

Coverage for your family member will end at 11:59 PM EST on the earliest of the following:

- The date your coverage ends.
- The date you stop being a member of a class that's eligible for family member coverage.
- The last day of the period for which the required premiums were paid.

- For a spouse, the last day of the month in which your marriage ends in divorce or annulment or your civil union or domestic partnership is dissolved.
- For a child, the last day of the month in which your child reaches the maximum age or no longer meets the conditions listed under **Keeping this coverage for a child who reaches the age limit.**
- The date the family member becomes ineligible for any of the reasons listed in the **Family members that aren't eligible** section.
- The date the family member dies.

If your coverage ends because of your death, your family members may continue their coverage in accordance with the **Family survivorship benefit.** See the **Family survivorship benefit** for more information.

B650.0505

Option A

Keeping this coverage for a child who reaches the age limit
A child may keep this coverage past the age limit if the child is all the following:

- Unable to live independently due to a mental, physical, or developmental disability, injury, illness, or condition which began before reaching the maximum age
- Primarily dependent upon you for financial support
- Continuously covered by this Plan, or by the group plan this Plan replaced, through the time the maximum age was reached

You'll have to send us proof that your child meets these requirements within 60 days of the date the maximum age was reached.

After two years have passed from the date the maximum age was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Coverage extended in accordance with this section will end when your child no longer meets the conditions above. Even when your child does meet the requirements listed above, this coverage can end due to any of the reasons, other than reaching the maximum age, listed under the **When family coverage ends** section.

B650.1135

Option A

Family survivorship benefit

If you die while you're covered by this Plan, we'll continue to provide coverage to any family members that were covered by this guide at the time of your death. This continued coverage will be provided at no cost to them.

We'll continue to cover your family members for 6 months after the date of your death. Coverage will end on the date this 6-month period ends.

This coverage will end sooner:

- For any family member whose coverage ends for other reasons - see the **Family coverage** section for more information
- For your spouse, upon remarriage
- If this Plan ends

Coverage will end on the date any of above occur.

If a family member elects to keep coverage under COBRA, the family survivorship benefit will be provided during the first 6 months of the continuation. See **COBRA continuation rights** for more information.

B650.0501

Other things you should know

Paying the premiums

For your insurance coverage to be in place, the required premiums must be paid. We worked with your Planholder to decide how and when the premium payments must be made.

The premiums can be changed at any time. We'll give your Planholder 31 days advance notice of any change in premiums.

If you have any questions about premium payments, please contact the Planholder.

Be sure to give us complete and accurate information

If we asked you to provide personal, health or medical information about yourself or your family members at the time of enrollment, it's important that the information you provided was complete and accurate. If it wasn't, we have the right to challenge a claim for benefits. This means we can deny a claim that might otherwise be covered.

If you don't give us complete and accurate information, we may also have the right to rescind this coverage. This means we would declare your guide to be null and void as of its effective date. In that case, we'd refund all the premiums paid and it would be as though your insurance coverage had never been issued.

During the first two years this guide is effective, we can rescind it if any material information you provided in or with an enrollment form or application was missing or inaccurate. Information is considered material if it would have caused us to:

- Not issue any coverage
- Issue your guide with different coverage or benefit amounts
- Issue your guide with different premium amounts

After this guide has been in place for more than two years, we can only rescind it if you committed fraud.

We won't challenge a claim or contest whether this coverage is valid unless the statement in question was made in writing and signed by you.

All statements made in your application will be considered representations, not warranties. This means you're asserting that the information you have listed on your application is accurate. You're not, however, promising to do anything for us if this assertion turns out to be false.

Any increase in benefits will be subject to these same requirements, with the two years described above beginning on the effective date of the increase.

Review the information you provided at the time of enrollment or application to make sure it's complete and accurate. If you find anything is missing or inaccurate, you must immediately notify us in writing at the address listed on the first page of this guide.

Misstatement of age

If your age or a family member's age is found to be incorrect, we may need to make an adjustment in the coverage and the premiums.

If the true age would have prevented us from issuing any coverage, this coverage will be terminated from the beginning and a refund of premiums will be made. Any benefits previously paid will be deducted from the refund.

Advance notice of change

We'll provide written notification at least 60 days prior to any of the following:

- Plan termination
- Premium increases
- Benefit reduction or elimination
- Eligibility restrictions

B650.1136

Guardian®

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

Covered services guide

This is the covered services guide

This guide explains the dental services that are covered and how much we'll pay.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-541-7846 **guardianlife.com**

Planholder: SAINT MARY'S COLLEGE OF CALIFORNIA

Plan Number: 00072651

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a network dentist may charge you their usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide to you a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call us at 1-888-GUARDIAN. To fully understand your coverage, you may wish to carefully review this document.

B651.1241

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Option A

Guide basics

Covered dental services

For a dental service to be considered for benefits:

- The service must be provided while you're covered by this Plan. If the service is for a family member, it must be provided while the family member is covered by this Plan. Unless we say otherwise in this guide, the date the dental service is performed will be the date we use to determine the benefits available.
- The service must be provided by a dental or medical practitioner who's properly licensed or certified by the state where the services are provided, and who provides dental services within the scope of this license or certification.
- The service must be provided within the professionally accepted standards of dental practices and be necessary and appropriate for your dental condition.
- The service must be covered by this guide.

There are many different dental services you can receive. This Covered Services Guide lists the most common services, but there can be other dental services not listed here that may also be covered. You or your dentist can contact us with any questions about any dental service you don't see in this guide.

Your dentist will give us a CDT (Current Dental Terminology) code to tell us which service you received. These CDT codes are approved by the American Dental Association and are used by all dentists.

Because dental terminology is updated from time to time, the most current dental terminology may not be reflected in this guide. We'll use the most current dental terminology when we receive your claim and determine the benefits payable.

Some dental services involve more than one procedure. Each procedure will be considered part of the overall service when we determine the benefits payable.

You and your dentist have the right and responsibility to decide upon the best course of treatment for you based on your dental needs, regardless of what benefits may be available. If more than one dental service can be used to treat your dental condition, we'll use the least costly option when we determine the benefits payable.

What we pay

In the Member Guide, we told you about deductibles and benefit maximums. In this guide, we'll give you the details on how much of the dentist's fees we'll pay.

How often

This is where we tell you how often you can have the service and receive the benefits available for that service.

Other things you should know

Here, we'll give you a brief description of each service and tell you other things you need to know about the benefits available.

B651.0006

Office Visits, X-rays & Cleanings - Diagnostic & Preventive Care

Office visits & evaluations

This section explains the benefits available when you go to the dentist for an office visit or evaluation.

Office visits, oral evaluations & comprehensive evaluations . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 2 time(s) every calendar year
- 1 time every 36 months for comprehensive evaluations per dentist

Other things you should know:
- These include any regular check-ups and dental evaluations.
- Office visits and evaluations count toward the same maximum number allowed.

Emergency problem-focused evaluations . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 time every 6 months

Other things you should know:
- This type of evaluation may be needed when there is a specific dental problem that needs attention right away.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

After-hours office visits & palliative treatment visits . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 time every 6 months

Other things you should know:
- After-hours visits take place outside normal office hours.
- Palliative treatment is provided to relieve pain or discomfort.
- After-hours visits and palliative treatment visits count toward the same maximum number allowed.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

X-rays - radiographic images

This section explains the benefits available for the various types of X-rays or images your dentist may take during your dental visit. Your dentist may refer to X-rays as radiographic images.

Complete series & panoramic X-rays . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 time(s) every 60 months

Other things you should know:
- A complete series captures an image of every tooth.
- A panoramic X-ray shows all the teeth, surrounding bone and other structures in the mouth.
- Complete series X-rays and panoramic X-rays count toward the same maximum number allowed.

Bitewing X-rays . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 time(s) every 12 months

Other things you should know:
- These X-rays show gum disease and cavities between the teeth.
- This benefit is available for a total of 4 bitewing images, or vertical bitewing images in 1 visit.

Intraoral periapical & occlusal X-rays . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- As needed

Other things you should know:
- A periapical X-ray is a single X-ray that shows the whole tooth, including the roots.
- An occlusal X-ray is a single X-ray that shows the roof or floor of the mouth.

Dental cleanings, preventive care & other diagnostic services

This section explains the benefits available for cleanings and other types of preventive care aimed at keeping your teeth and gums healthy.

Dental cleanings . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 2 time(s) every calendar year
- 1 time every 12 months for a medically necessary cleaning

Other things you should know:
- This removes plaque, tartar, and stains from the teeth. It can be performed by a dentist or dental hygienist. Your dentist may call this a prophylaxis.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- This benefit for an additional cleaning is available if the cleaning is needed because of health conditions.
- We may ask that your physician provide a written explanation of why an additional cleaning is needed.

Fluoride . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 2 time(s) every calendar year

Other things you should know:
- This helps prevent cavities by strengthening the outer surface of the teeth. Fluoride can be applied to the teeth as a mouth rinse, gel, or foam.
- This benefit is only available for those under the age of 19.

Sealants . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth every 36 months

Other things you should know:
- These are thin, protective resin coatings that adhere to the chewing surface of the back teeth to help prevent cavities.
- This benefit is only available for those under the age of 16.
- This benefit is only available for adult (permanent) molar teeth that don't already have fillings or other treatments on the tooth.

Space maintainer . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 appliance during the lifetime of this plan

Other things you should know:
- This appliance helps preserve space for adult (permanent) teeth when 1 or more baby (primary) teeth are lost too early.
- This benefit is available only for those under the age of 16.
- This benefit is available for 1 bilateral space maintainer for the upper teeth and 1 for the lower teeth, or 1 unilateral space maintainer per quadrant.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the space maintainer, including adjustments made within 6 months and re-cementations made within 12 months of the space maintainer being inserted, will be considered part of the space maintainer.

Harmful habit appliance . . . . . **Preventive**

What we pay:
- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:
- 1 appliance during the lifetime of this plan

Other things you should know:
- This appliance is temporarily cemented to certain teeth to prevent a child from sucking a thumb, finger, or pacifier.
- This benefit is available only for those under the age of 14.

Dental model . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 model

Other things you should know:
- These are replicas of the upper or lower teeth and are made of stone or plaster. Your dentist may call this a diagnostic cast.
- This benefit is only available when 3 or more of the following are needed at the same time for both the upper and lower teeth:
  - Dentures
  - Crowns
  - Bridges
  - Onlays
  - Full mouth adjustment of the bite

Fillings, Crowns & Other Repairs - Tooth Restorations

Fillings

This section explains the benefits available for dental fillings.

Fillings . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth surface every 12 months for those under the age of 19 and 1 time per tooth surface every 36 months for those age 19 and older.

Other things you should know:

- These are used to restore a tooth damaged by decay or when part of a tooth has broken off. Your dentist may call a silver-colored filling an amalgam restoration. Your dentist may call a tooth-colored filling a resin or composite restoration.
- All services associated with a filling, such as bonding agents, liners, bases, polishing, bite adjustments, and local anesthetic, will be considered part of the filling.

Crowns

This section explains the benefits available when you have a crown placed on a tooth.

Crowns . . . . . **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a crown. This is sometimes called a cap.
- A crown can be made of metal, porcelain (a tooth-colored material), or both, where porcelain covers the metal underneath.
- This benefit is available only when the crown is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- A crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and it can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a crown, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the crown.
- The day the tooth is prepared for the crown will be considered the date the service is performed.

Prefabricated crowns . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth every 24 months

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a prefabricated crown. Prefabricated crowns are usually used on baby (primary) teeth.
- A crown can be made of stainless steel, porcelain (a tooth-colored material), resin (also a tooth-colored material) or a combination, where porcelain covers the metal underneath.
- When a prefabricated crown is replaced within 24 months by a permanent crown, the prefabricated crown will be considered temporary and part of the permanent restoration.

Other tooth restoration services

This section explains the benefits available for other types of restorations or repairs your teeth may need.

Onlays & labial veneers . . . . . **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used when a filling can't be used to restore a tooth damaged by decay or replace a part of the tooth that has broken off.
- Onlays are like crowns, but instead of covering the entire tooth, they cover only the damaged part of the tooth.
- A veneer is a tooth-colored material that's placed on the front of the tooth. These are used on anterior teeth only. These are the incisor and cuspid teeth located in the front of the mouth.
- This benefit is available only when the restoration is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain onlay is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For an onlay placed on a molar tooth, what we pay will be based on the cost of an all-metal onlay
- The benefit for a noble metal onlay is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal onlay.
- An onlay or veneer that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with the restoration, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the restoration.
- The day the tooth is prepared for the restoration will be considered the date the service is performed.

Core buildup & post & core . . . . . **Major**

What we pay:
- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- A core buildup and a post and core are done to strengthen a tooth that has been broken or damaged by decay so a crown can be placed.
- This benefit is available only when this service is done with a covered crown or bridge retainer and when needed because of substantial loss of tooth structure.
- This benefit is available for adult (permanent) teeth only.

Crown & restoration repairs . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- Sometimes a crown, onlay or veneer can be repaired instead of replaced.

Re-cement & re-bond . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- Sometimes a crown, onlay or veneer may need to be re-cemented or re-bonded.
- This benefit is available if the re-cement or re-bond is done more than 12 months after the placement of the restoration.

Root Canals & Related Services - Endodontic Care

Root canals

This section explains the benefits available when you have a root canal performed.

Root canal - anterior & bicuspid teeth . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Root canal - molar teeth . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Other endodontic services

This section explains the benefits available for other endodontic procedures.

Pulp cap . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time per tooth

Other things you should know:
- This is a special material placed underneath a filling to protect the nerve inside the tooth.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a pulp cap, such as X-rays, cultures and tests, local anesthetic, temporary filling, and routine follow up care, will be considered part of the pulp cap.

Pulpotomy . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This involves removing the nerve inside the tooth.
- When a root canal is the final treatment, this service will be considered part of the root canal.
- All services for treatment associated with a pulpotomy, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the pulpotomy.

Apicoectomy, retrograde filling & root amputation . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time per tooth root for each procedure

Other things you should know:
- An apicoectomy is the surgical removal of the tip of the tooth root.
- A retrograde filling is used to seal the site of the root tip removal.
- A root amputation is the surgical removal of a root from a tooth that has multiple roots.
- All services associated with these procedures, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the procedure.

Periodontal Care - Treatment of Gum Disease & Related Services

Non-surgical periodontal services

This section explains the benefits available when you receive periodontic care that doesn't involve surgery.

Periodontal maintenance . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 2 time(s) every calendar year

Other things you should know:
- This is a specialized cleaning that may be needed after any type of previous periodontal treatment. Your dentist may call this a periodontal prophylaxis or periodontal cleaning.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- All services associated with periodontal maintenance, including the treatment plan, charting, scaling, polishing, local anesthetic, and post- treatment care, will be considered part of the periodontal maintenance.

Scaling & root planing . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per quadrant every 24 months

Other things you should know:
- This is a cleaning of tooth surfaces both above and below the gumline. It may be necessary when there's periodontal disease and chronic inflammation in the gum tissue around the teeth that causes a breakdown in some of the nearby bone.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the scaling and root planing, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the scaling and root planing.

Full mouth debridement . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time during the lifetime of this plan

Other things you should know:
- This is an extensive cleaning needed when the teeth can't be examined because of a significant amount of plaque and buildup on them.
- All services associated with the debridement, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the debridement.

Periodontal surgery

This section explains the benefits available when you have periodontic surgery.

Gingivectomy, gingivoplasty (1 to 3 teeth) & crown lengthening . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 surgical procedure per tooth every 12 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Crown lengthening removes a small amount of bone and gum tissue around a tooth to make a crown fit better.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray. This benefit will be available for a gingivectomy of 1 tooth when there is documented inflammation of the gum tissue.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Gingivectomy, gingivoplasty (4 or more teeth), osseous surgery, gingival flap procedure, mesial/distal wedge procedure & surgical revision procedure . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 surgical procedure per quadrant every 36 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Osseous surgery reshapes the bone around the tooth.
- Gingival flap, mesial/distal wedge and surgical revision procedures reshape the gum tissue around a tooth, teeth, or spaces without teeth.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Tissue graft . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth or site every 36 months

Other things you should know:
- This involves replacing gum tissue that has been lost around the root area of a tooth.
- This benefit is available only when there's documentation of progressive loss of gum tissue due to disease.
- This benefit is available only when the tooth is present.
- All services associated with the graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the graft.

Guided tissue regeneration . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth or site

Other things you should know:
- This is used to replace gum tissue. It's frequently done with a bone graft to replace bone that has been lost.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the regeneration, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care will be considered part of the regeneration.

Bone replacement graft . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time(s) per tooth or site

Other things you should know:
- This involves replacing bone tissue that has been destroyed by periodontal disease.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss thats verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the bone graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the bone graft.

Periodontal related services

This section explains the benefits available for other periodontal related services.

Limited occlusal adjustment . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 2 visits

Other things you should know:

- This is a minor adjustment of the biting surfaces of 1 or more teeth.
- This benefit will be available only for adjustments made within 6 months after osseous surgery and scaling and root planing.

Occlusal guard . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 appliance during the lifetime of this Plan

Other things you should know:

- This appliance covers some or all the teeth. There are different types of guards used for different types of treatment.
- This benefit is available only when the guard is received within 6 months after osseous surgery.

Bridges & Dentures - Prosthodontics

Bridges

This section explains the benefits available when you have a bridge made and placed.

Bridges . . . . . **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the bridge must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- This a fixed prosthetic that replaces 1 or more missing teeth and is held in place by adjacent teeth. Your dentist may refer to the false teeth as pontics and to the adjacent teeth as abutments.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain bridge is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a bridge placed on molar teeth, what we pay will be based on the cost of an all-metal bridge.
- The benefit for a noble metal bridge is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal bridge.
- A bridge that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a bridge, including insulating bases, temporary or provisional restorations, local anesthetic, or gingival involvement, will be considered part of the bridge.
- The day the tooth is initially prepared for the bridge will be considered the date the service is performed.

Dentures

This section explains the benefits available when you have a denture made and placed.

Dentures - partial & complete . . . . . **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time every 5 years for each denture
- For a replacement, the denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are removable dental prostheses used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete denture replaces all the upper teeth or all the lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- The day the final impression is taken for the denture will be considered the date the service is performed.
- If a temporary, interim, or provisional denture is in place for more than 1 year, it will be considered a permanent denture.
- All services associated with a denture, including a temporary denture and adjustments made in the first 6 months after the denture is placed, will be considered part of the denture.
- A denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bridge & denture repairs & maintenance

This section explains the benefits available when a bridge or denture needs to be repaired or modified.

Bridge repairs . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- A bridge may need to be repaired due to wear or other damage.

Denture repairs . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- A denture may need to be repaired due to wear or other damage.

Denture adjustments . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- Adjustments involve making changes to the denture to ensure a proper fit.
- Any charges for denture adjustment done within 6 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the adjustment is done more than 6 months after the denture was placed or more than 6 months after the most recent denture rebase or denture reline.

Adding teeth to partial dentures . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- A partial denture may need to be modified if additional teeth are lost after it was first placed.

Denture rebase . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time per denture every 24 months

Other things you should know:
- This involves replacing the entire acrylic denture base without replacing the artificial teeth.
- Any charges for a denture rebase done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the rebase is done more than 12 months after the denture was placed.

Denture reline . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time per denture every 24 months

Other things you should know:
- This involves reshaping the denture base to make it more comfortable.
- Any charges for a denture reline done within 12 months after the denture was placed will be considered part of the fee for the denture if its done by the same dentist that provided the denture.
- This benefit is available only when the reline is done more than 12 months after the denture was placed.

Tissue conditioning . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- 1 time for the upper denture and 1 time for the lower denture every 12 months

Other things you should know:
- This is a temporary cushion placed inside a denture to improve fit and comfort following an extraction or other surgical procedure.
- Any charges for tissue conditioning done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.

Dental Implants

Implants

This section explains the benefits available when you have a dental implant placed.

Radiographic/surgical implant index . . . . . **not covered**

Surgical placement of implant . . . . . **not covered**

Other implant related services

This section explains the benefits available for other services related to dental implants.

Implant abutments - prefabricated & custom fabricated . . . . . **not covered**

Implant/abutment-supported crowns . . . . . **Major**

What we pay:
- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:
- 1 time per tooth every 5 years
- For a replacement, the implant crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- These are screwed or cemented onto the abutment to replace the missing tooth.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported dentures . . . . . **Major**

What we pay:
- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:
- 1 time per denture every 5 years
- For a replacement, the implant denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:
- These are used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete implant denture replaces all the upper teeth or lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- An implant denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bone replacement graft for ridge preservation . . . . . **not covered**

Implant repairs & removal

This section explains the benefits available when you have an implant abutment, crown or denture that needs to be repaired or an implant that needs to be removed.

Implant crown & implant denture repairs . . . . . **not covered**

Implant abutment repairs . . . . . **not covered**

Implant removal . . . . . **not covered**

Tooth Extractions & Oral Surgery

Extractions

This section explains the benefits available when you have a tooth removed.

Non-surgical extractions . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This is done to remove a tooth or root that's above the gumline.
- All services associated with the extraction, such as the treatment plan, local anesthetic, and post-treatment care, will be considered part of the extraction.

Complex surgical extractions . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- This is done when the extraction involves cutting the gums or bone to remove the tooth or roots.
- All services associated with the extraction, such as the treatment plan, local anesthetic, suturing and post-surgical care, will be considered part of the extraction.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information.

Other oral surgery services

This section explains the benefits available for other oral surgery procedures.

Other complex oral surgeries . . . . . **Basic**

What we pay:
- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:
- As needed

Other things you should know:
- Other types of oral surgery may be needed to treat oral diseases, injuries, and defects.
- All services associated with the surgery, such as X-rays, the treatment plan, local anesthetic, suturing, and post-surgical care, will be considered part of the surgery.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information

Other Dental Services

This section explains the benefits available when you receive one of the following services.

Anesthesia . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- This is a drug administered during procedures to reduce pain or discomfort. This includes:
  - Deep sedation/general anesthesia
  - Intravenous conscious sedation
  - Non-intravenous conscious sedation
  - Nitrous oxide
- This benefit is available only when the anesthesia is administered with a covered surgical service.

Consultations . . . . . **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time for each dental specialty every 12 months

Other things you should know:

- This is an examination performed by a specialty dentist or a dentist other than your usual dentist.
- This benefit is available only when the dentist providing the consultation isn't the same dentist providing your treatment.
- This benefit is available only when no other services, other than X-rays, are performed during the consultation. If other services are performed, refer to those services for the benefits available.

Orthodontic Care

This section explains the benefits available when you have your teeth straightened or realigned.

Orthodontic services . . . . . **Orthodontic**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- These services correct the position of the teeth and jaw.
- This benefit is available for adults and children.
- This benefit is available for the orthodontic treatment plan and records, including impressions, X-rays, photographs, study models, braces or clear aligners, periodic visits, and retainers.
- This benefit will be divided into equal payments and will be made over the length of the treatment plan or 2 years, whichever is shorter. The first payment will be made when the appliances are initially placed. The remaining payments will be made at the end of every quarter.
- If the orthodontic treatment began before your coverage under this Plan started, the treatment will be pro-rated. For example, if 40% of the treatment was completed before coverage under this Plan began, only the remaining 60% will be considered.
- The day the appliances are first placed will be considered the date the service begins.
- Any benefits that were paid for orthodontic services under a prior plan will reduce the orthodontic lifetime maximum by an equal amount. See the Benefit maximums section of the Member Guide for more information.
- Discounts offered by dentists in our network aren't available for:
  - Additional charges for optional orthodontic appliances
  - Replacement or repair of an orthodontic appliance needed due to neglect
  - Orthodontic treatment plans that began before you became eligible for benefits for orthodontic services under this plan.
- There's a maximum amount of benefits that will be paid for orthodontic care. See the **Benefit maximums** section for this amount.

What isn’t covered - exclusions

This section explains the services that aren’t covered by this Plan.

No benefits are available for:

- Any service for which there is no charge
- Any service that doesn’t meet professionally recognized standards of dental practice or that’s considered to be experimental
- Any service that’s performed in conjunction with or related to a service that isn’t covered by this guide
- Any service on a tooth with a guarded, questionable, or poor prognosis
- Any service that’s used solely to:
  - Alter occlusal vertical dimensions
  - Restore or maintain occlusion
  - Treat a condition resulting from attrition, abrasion, erosion or abfraction
  - Splint or stabilize teeth for periodontal reasons
- Replacing extracted or missing wisdom teeth
- Localized use of antimicrobial agents into diseased crevicular tissue
- Any service that’s provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge
- A temporary or provisional appliance or dental prosthesis, unless it’s an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- A bridge that replaces the extracted portion of a hemisected tooth
- The placement of more than one crown or bridge unit per tooth
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture
- Detailed and extensive oral evaluations
- Any service that’s educational or instructional, such as oral hygiene instruction, tobacco counseling or nutritional counseling
- Bite registration, bite analysis or occlusion analysis - mounted case
- Duplication of X-rays
- Completion of claim forms
- OSHA or other infection control measures
- Cephalometric X-rays
- Cone beam images
- Oral or facial photographs
- Prescription medication
- Application of desensitizing medications and resins
- Separate charges for local anesthesia
- Pulp vitality tests
- Caries susceptibility tests
- Specialized techniques
- Precision attachments
- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition
- Treatment of congenital or developmental malformations
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ)
- Any service coded by the dentist as unspecified

- The isolation of a tooth with a rubber dam
- Gingival irrigation
- Medications dispensed in a dental office for home use

B651.1326

Option A

Here is a notice to help you better understand your rights if your Plan is governed by ERISA. The notice isn't part of the group insurance policy or member guide.

B651.1025

Option A

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 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 and Qualified Domestic Relations Order

Federal law required that group health plans provide medical coverage for 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 plan administrator.

The plan administrator 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. The plan administrator has discretionary authority to determine eligibility for benefits and coverage under those documents. The plan administrator 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, the plan administrator 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.

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. The plan administrator, or its designee, 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.

The plan administrator, or its designee, 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 the plan administrator, or its designee, 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 the plan administrator, or its designee, 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 the plan administrator, or its designee, 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, the plan administrator, or its designee, 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. The plan administrator, or its designee, 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 relevant 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, the plan administrator, or its designee, 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 judgement, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify dental or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

The plan administrator, or its designee, 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 the plan administrator, or its designee, 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 the plan administrator, or its designee, 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.

B651.1054

Employer-Funded Benefits Not Insured By Guardian

This Certificate explains the coverage your Employer offers. It explains the benefits available, as well as the requirements and limits of this coverage.

This is not insurance provided by Guardian. Instead, your Employer has engaged Guardian only to provide administrative services, such as processing claims. Your Employer's funds will be used to pay these claims. Your Employer is solely responsible and liable for the benefits available under this Plan.

B115.0130

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

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

GROUP VISION COVERAGE

This evidence of coverage verifies that the Employee to whom this booklet is issued is covered by the Plan Sponsor for the benefits described herein, provided the eligibility requirements are met.

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

Employer: SAINT MARY'S COLLEGE OF CALIFORNIA

Group Plan Number: 00072651

Michael Prestileo,
Senior Vice President

Harris Oliner, Senior Vice President
and Corporate Secretary

B435.0980

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IMPORTANT NOTICE

The Vision Care 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.

B040.0895

All Options

NOTICE: WE WILL PROVIDE WRITTEN NOTIFICATION BY MAIL TO THE LAST KNOWN ADDRESS OF ALL AFFECTED NONEMPLOYEE CERTIFICATE HOLDERS AT LEAST 60 DAYS PRIOR TO THE EFFECTIVE DATE OF THE FOLLOWING: TERMINATION OF THE PLAN, INCREASE IN PREMIUM, REDUCTION OR ELIMINATION OF BENEFITS OR RESTRICTION OF ELIGIBLITY NOT REQUESTED BY THE PLANHOLDER.

SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS INSURANCE, YOU MAY CONTACT THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA AS SHOWN BELOW.

COMPLAINT NOTICE

This notice is to advise You that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

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

If you feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department Of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1 (800) 927-HELP (4357)
TDD: 1 (800) 482-4TDD (4833)
Website: www.insurance.ca.gov/01-consumers/

B435.1293

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, subject to a grace period of 31 days.

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 during the 2 years from its date of issue, We will refund premiums paid for the periods such insurance is void.

B435.1294

CONDITIONS OF ELIGIBILITY FOR GROUP VISION INSURANCE COVERAGE

B435.0005

All Options

Employee Eligibility

You are eligible for vision coverage if You are:

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

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

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

Enrollment: If You must pay all or part of the cost of Employee coverage, You must enroll and agree to make required payments within 31 days of Your eligibility date. If You fail to do this, You cannot enroll until the plan's next vision open Enrollment Period. "Open Enrollment period" means an annual open enrollment period set up by the Employer and agreed to by Us.

This plan's vision open Enrollment Period occurs from December 1st to December 31st of each year.

Once You enroll in this plan, You cannot drop Your or Your dependent's vision coverage until this plan's next vision open Enrollment Period. Once You drop Your or Your dependent's vision coverage, You will not be permitted to enroll again until the next vision open Enrollment Period which starts after the date coverage is dropped.

If You initially waived vision coverage under this plan because You were covered under another group vision care plan, and You wish to enroll in this plan because Your coverage under the other plan ended, You may do so without waiting until the next vision open Enrollment Period. But, Your coverage under the other plan must have ended due to one of the events listed below:

- Termination of Your Spouse's employment.

- Loss of eligibility under Your Spouse's vision plan.
- Divorce.
- Death of Your Spouse.
- Termination of the other vision plan.

In that case, You must enroll in the vision coverage under this plan within 30 days of the date that any of the events listed above occurs.

B435.0970

All Options

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
  - A child who is incapable of self-support because of a physical or mentally disabling injury, illness or condition. 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
    - We will send notice to You to send Us written proof that the child is dependent upon You for support and maintenance and is incapable of self-sustaining employment by reason of a disabling physical or mental injury, illness, or condition. You have 60 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 We cannot ask for this proof more than once a year.

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

B435.1295

All Options

Eligibility Waiting Period

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

B400.0087

All Options

When Coverage Starts

Your Employer will inform You of Your Effective Date under the Group Vision Policy. Your coverage begins on the date:

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

B435.0036

All Options

Exception to When Coverage Starts

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

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

and if:

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

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

B400.0094

All Options

Family Status Change

You may request the addition of Vision Insurance Coverage if You have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request the addition of Vision Insurance Coverage for which You were not previously insured. You must provide proof of the Family Status Change and request the addition of Vision Insurance Coverage in writing within 31 days after the date of the Family Status Change as described above.

Refer to the When Coverage Starts section for information regarding when this coverage is effective.

B435.0981

All Options

When Your Coverage Ends

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

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for or by You.
- The date You die.

B435.0536

When Your Dependent Coverage Ends

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

- When Your coverage ends.
- When You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- 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.

B400.0115

CONTINUATION OF COVERAGE

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

Continuation Rights

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

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

Uniformed Services Continuation Rights

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

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

You may contact Your Employer for additional information.

COBRA Continuation Rights

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

Family Medical Leave Of Absence (FMLA)

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

B435.0038

Dependent Survivorship Benefit

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

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

B435.0040

VISION CLAIM PROVISIONS

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

Your reimbursement will be based on VSP's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

B435.0520

All Options

Filing A Claim

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

If You have services performed by a Non-Preferred Provider, You will need to submit Your own claim.

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate. We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to Notice and Proof of Loss.
- Consider and interpret the terms of this Certificate and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Certificate and applicable state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant, within a reasonable period of time, a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Notice: You must send Us written notice for which a claim is being made within 20 days of the service. We will not void or reduce Your claim if You cannot send Us notice of claim within the required time. In that case, You must send Us notice of claim as soon as reasonably possible. This notice should include his or her name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

Claim Forms: We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, You will be considered to have complied with the requirements of the Certificate as to proof of loss and We will accept a written description and adequate proof of the service that is the basis of the claim as proof of loss. You must detail the occurrence, the character and the extent of the loss for which claim is made.

Proof Of Loss: You must send written proof of loss to Our designated office within 90 days of the loss. We will not void or reduce Your claim if You cannot send Us proof of loss within the required time. In that case, You must send Us proof as soon as reasonably possible. However, under no circumstances will We pay benefits if written proof of loss is delayed for more than one year, unless You are unable to provide proof of loss because You are not legally competent or You lack legal capacity.

Payment Of Benefits: We will pay Vision benefits immediately after We receive written proof of loss, subject to all the terms and conditions of this Policy.

Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living. If You are not living, Vision benefits shall be paid to Your estate, except that We may pay all Vision benefits, up to an amount not exceeding $1000, to one of the following:

Your:

- Spouse;
- Parents;
- Children; or
- Brothers and sisters.

Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

All claims must be sent to VSP within one year of the date services are completed or supplies are received. To obtain a claim form visit Our website at www.guardianlife.com.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

Legal Actions: No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after 3 years from the date of the final benefit determination.

Workers' Compensation: The Vision benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B435.1301

All Options

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 You have 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.

B400.3339

All Options

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, You 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 You 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 You 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 You 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 You of its decision not later than 60 days after receipt of the request for review of the adverse determination.

External Reviews And Independent Medical Reviews

In the event that You believe a claim was improperly denied, modified or delayed by Guardian or one of Our providers due to the proposed health care services being not medically necessary, You have the right to request an Independent Medical Review (IMR) by the California Department of Insurance (CDI). You must request an external review within 60 days receipt of the adverse benefit determination notice.

With regard to experimental or investigative therapies, We will notify You of the right to request an IMR within 5 business days of the adverse benefit determination notice. If Your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, You can request an expedited review and the analyses and recommendations of the panel of experts will be rendered within seven days of the request for expedited review. At the request of the expert(s), the deadline can be extended by up to three days. The IMR for experimental and investigative therapies will follow the standard procedures except that the reviewer will base his or her determination on relevant medical and scientific evidence.

You can request an IMR by following the steps outlined below.

1. Notify the CDI to request an IMR by filling out an application.
2. Agree and provide written consent to participate in an IMR.
3. The CDI will determine if the request is eligible for an IMR.
4. The IMR Organization will have 30 days to review once all information is gathered unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to You, Guardian and the Insurance Commissioner.
6. The Commissioner will adopt the recommendation of the IMR organization and promptly notify You and Guardian. The decision is binding to Guardian.

B400.3340

All Options

VISION EXPENSE BENEFITS

This coverage will pay many of a Covered Person's vision care expenses. We pay benefits for Covered Charges incurred by a Covered Person. What We pay and the terms for payment are explained below.

This Certificate includes the Schedule(s) of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

B435.0043

All Options

Vision Service Plan (VSP) - This Plan's Vision Care Preferred Provider Organization

The Policy is designed to provide high quality vision care while controlling the cost of such care. To do this, the Policy encourages a Covered Person to seek vision care from vision care practitioners and vision care facilities that belong to VSP, a vision care Preferred Provider Organization (PPO).

The vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. When a Covered Person is enrolled in the Policy, he or she will get an enrollment packet. The packet will: (1) explain how to obtain benefits; and (2) contain information about current vision care Preferred Providers. He or she will also receive information on how to obtain a list of VSP Preferred Providers in his or her area.

A Covered Person may receive vision services from any VSP Preferred Provider. If a Preferred Provider ends his or her relationship with VSP for any reason, VSP will be responsible for furnishing vision services to Covered Persons either through that provider or another VSP Preferred Provider.

Use of the vision care PPO is voluntary. A Covered Person may receive vision care from any vision care provider he or she chooses. And he or she is free to change providers at any time. But, the Policy usually pays more in benefits for covered services furnished by a Preferred Provider. Conversely, it usually pays less for covered services not furnished by a vision care Preferred Provider.

What We pay is based on all of the terms of the Policy. Please read this Certificate carefully for specific benefit levels, Copayments, Deductibles, Payment Rates and Payment Limits.

A Covered Person may call VSP should he or she have any questions about the vision coverage.

VSP Customer Care

877-814-8970

Obtaining Services from a Preferred Provider

When a Covered Person wishes to receive services from a Preferred Provider, he or she must contact the Preferred Provider before receiving the services. The Preferred Provider will contact VSP to verify the Covered Person's coverage.

What We pay for charges for covered services is subject to all of the terms of this Certificate.

B435.0989

All Options

Continuity Of Care

At Your request, We can arrange for the completion of covered services by a terminated Preferred Provider for the duration of an Acute Condition. A terminated Preferred Provider means a vision care practitioner whose contract to provide services to Covered Persons is terminated or not renewed by Us or one of Our contracting vision groups. A terminated Preferred Provider is not a vision care practitioner who voluntarily leaves Us or Our contracting vision group. You must be undergoing a course of treatment for an Acute Condition and Your coverage under the Policy must continue during the completion of covered services.

B435.0511

All Options

How This Plan Works

We pay benefits for the covered charges a Covered Person incurs as shown below. The services and supplies covered under this Certificate are explained in Covered Services and Supplies. What We pay is subject to all of the terms of this Certificate. Read the entire Certificate to find out what We limit or exclude.

Covered charges are the charges for the services and supplies described below. We pay benefits only for covered charges Incurred by a Covered Person while he or she is covered by this Certificate. Charges in excess of any Payment Limits shown in this Certificate are not covered.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive authorization from VSP. See Obtaining Services from a Preferred Provider. If authorization is not received, benefits will be paid as if services and supplies were received from a Non-Preferred Provider.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. Please refer to Vision Claim Provisions in this Certificate.

Copayments: A Covered Person must pay a Copayment each time he or she receives a vision examination. And, he or she must pay a Copayment each time he or she receives lenses or a frame or a complete pair of eyeglasses covered by this Certificate. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Certificate's Copayments are shown in the Schedule Of Benefits.

Cash Deductibles: There are separate cash Deductibles for each covered service furnished by a Non-Preferred Provider. These cash Deductibles are shown in the Schedule of Benefits. The Covered Person must have covered charges in excess of the cash Deductible before We pay benefits for the service or supply. The cash Deductible will be subtracted from the reimbursement to the member.

Payment Limits: Payment limits, durational or monetary, are shown in the Covered Services and Supplies. When a monetary Payment Limit is set for a pair of materials, the limit is halved if only one item is purchased.

Payment Rates: Once a Covered Person has paid any applicable Copayment or Deductible, We pay benefits for covered charges under this Certificate at the Payment Rate shown in the Schedule Of Benefits. What We pay is subject to all of the terms of this Certificate.

B435.1311

All Options

Covered Services And Supplies

This section lists the types of charges We cover. But, what We pay is subject to all of the terms of this Certificate. Read the entire Certificate to find out what We limit or exclude.

B435.0048

All Options

Vision Examinations: We cover charges for comprehensive vision care examinations of visual functions and prescription of corrective eyewear. We only cover charges for one vision examination for each Covered Person in any one calendar year Benefit Period. The comprehensive vision care examination does not include a contact lens exam (evaluation and fitting).

If a Covered Person receives a vision examination from a Preferred Provider, We pay benefits in full for the covered charges for that examination.

If a Covered Person receives a vision examination from a Non-Preferred Provider, We pay benefits for the covered charges for that examination, up to $39.00.

B435.0049

All Options

Vision Materials We cover charges for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We cover charges for frames. And, We cover charges for prescription contact lenses. Benefit allowances provide no remaining balance for future use within the same Benefit Period, except for Contact Lens benefit.

In any one calendar year Benefit Period We cover charges for either glasses or contact lenses, but not both.

B435.0060

All Options

Standard Lenses: We cover charges for single vision, bifocal, trifocal or Lenticular Lenses. They must be glass or plastic lenses or for dependent children to age 19, Polycarbonate Lenses.

B435.0578

All Options

We only cover charges for one pair of Standard Lenses in any one calendar year Benefit Period.

B435.0583

All Options

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) $23.00 for each pair of single vision lenses; (2) $37.00 for each pair of bifocal lenses; (3) $49.00 for each pair of trifocal lenses; and (4) $64.00 for each pair of Lenticular Lenses.

B435.0590

All Options

We pay the following benefits in full when a Covered Person purchases lenses from a Preferred Provider:

B435.0592

All Options

- Progressive Multi-Focal Lenses

B435.0063

All Options

If the Covered Person chooses elective contact lenses, We do not cover Standard Lenses for one calendar year from the date the elective contact lenses are purchased.

B435.0597

All Options

Standard Frames: We cover charges for Standard Frames.

If a Covered Person uses a Preferred Provider, We cover charges up to a retail frame allowance of $130.00.

If a Covered Person uses a Non-Preferred Provider, We limit what we pay for each set of Standard Frames to $46.00.

We only cover charges for one set of Standard Frames in any one calendar year Benefit Period.

If the Covered Person chooses elective contact lenses, We do not cover Standard Frames for one calendar year from the date the elective contact lenses are purchased.

B435.0714

All Options

Necessary Contact Lenses: We cover charges for necessary contact lenses but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover necessary contact lenses and charges for related professional services but only if the lenses are needed: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for certain conditions of: Anisometropia or Keratoconus.

And, We only cover charges for one pair of necessary contact lenses in any one calendar year Benefit Period.

If a Covered Person receives necessary contact lenses from a Preferred Provider, We pay 100% of the covered charges.

If a Covered Person receives necessary contact lenses from a Non-Preferred Provider, We limit what We pay for covered charges for such lenses to $210.00 in any one calendar year Benefit Period.

B435.0616

All Options

Elective Contact Lenses: We cover charges for elective contact lenses, but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses.

If the Covered Person chooses elective contact lenses, We do not cover charges for Standard Lenses for one calendar year and Standard Frames for one calendar year from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for elective contact lenses to $130.00

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for elective contact lenses to $100.00.

We cover charges for one set of elective contact lenses in any one calendar year Benefit Period.

Charges are covered up to the contact lens allowance. The allowance may be applied towards an elective contact lens Fitting and Evaluation at some provider locations.

B435.1116

All Options

Low Vision Benefits: We pay benefits for the covered charges at the Payment Rates shown in the Schedule of Benefits provided to a Covered Person who has severe visual problems which cannot be corrected with Standard Lenses.

Low Vision services are Low Vision Supplementary Testing and Low Vision Supplemental Care.

If a Covered Person receives Low Vision Supplementary Testing, We pay benefits for the covered charges for the testing up to $125.00 per test.

We cover no more than two Low Vision Supplementary Test(s) per Covered Person in any 24 month Benefit Period.

We limit what We pay for all covered Low Vision services, including any amount paid for Low Vision Supplementary Testing, to $1,000.00 per Covered Person in any 24 month Benefit Period.

B435.1126

All Options

Exclusions

No benefits will be paid for services or materials connected with, or charges arising from:

- Orthoptics or vision training and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures.
- Any vision examination or corrective eyewear or safety eyewear required by an employer as a condition of employment unless specifically covered under this Certificate.
- Services or materials provided by any other group benefit plan providing vision care.
- Plano Lenses (non-prescription lenses with less than a +/- .50 diopter power).

- Plano contact lenses to change eye color cosmetically or artistically painted contact lenses.
- Non-prescription sunglasses.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses, frames, glasses or contact lenses furnished under this Certificate which are lost or broken, except at normal intervals when services are otherwise available.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses, such as polishing or cleaning or modifications to contact lenses.
- Corneal refractive therapy (CRT) or orthokeratology (using contact lenses to change the shape of the cornea to reduce myopia).
- A frame that costs more than this Certificate allowance.
- Unused allowance amounts cannot be banked for future use. The allowance must be used during the same office visit.
- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.

B435.1337

All Options

- Anti-Reflective Coating of the lens or lenses.

B435.0090

All Options

- Photochromic Lenses.

B435.0092

All Options

- Ultraviolet Coating of lenses.

B435.0093

All Options

- Scratch Resistant Coating.

B435.0095

All Options

- High Index Lenses.

B435.0096

All Options

- Polycarbonate Lenses for adults.

B435.0097

All Options

- Polarized/Laminated Lenses.

B435.0098

All Options

- Oversize Lenses.

B435.0636

All Options

- Mirror and Ski Coating.

B435.0099

All Options

- Edge Treatment.

B435.0100

All Options

- Tinted Lenses.

B435.0637

All Options

- Blended Lenses.

B435.0101

All Options

Charges not covered due to these exclusions are not considered charges for covered vision services and cannot be used to satisfy this Certificate's Copayments or Deductibles, if any.

B435.0147

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

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

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

B435.0518

All Options

Acute Condition: This term means a vision condition that involves a sudden onset of symptoms due to a vision problem that requires prompt vision attention and that has a limited duration.

B435.0516

All Options

Anisometropia: This term means a condition in which two eyes have unequal refractive power. Each eye can be nearsighted (myopia), farsighted (hyperopia), or a combination of both, which is called antimetropia. Generally a difference in power of two diopters or more is the accepted threshold to label the condition anisometropia.

B435.1044

All Options

Anti-Reflective Coating: This term means a clear lens coating that limits light reflection by allowing the maximum amount of light to pass through the lens.

B435.0105

All Options

Benefit Period: This term means the time period beginning when a covered service is received and extending for the period shown in this Certificate, during which benefits for the covered service are available to a Covered Person.

B040.0846

Blended Lenses: This term means bifocals which do not have a visible dividing line.

B040.0847

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

B435.0108

Copayment: This term means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a Covered Person to a Preferred Provider at the time covered services are received.

B435.0109

All Options

Corneal Disorders: This term means any condition (other than Keratoconus) of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes.

B435.0110

All Options

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

B435.0185

All Options

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

B435.0111

All Options

Edge Treatment: This term means a cosmetic service to make the sides of a cut lens look clear rather than a milky white.

B435.0112

All Options

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

B435.0113

All Options

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

B435.0114

All Options

Employee: This term means the member of the group determined to be eligible by the Employer.

B435.0115

All Options

Employer: This term means the entity that purchased the Policy.

B435.0116

All Options

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B040.0856

All Options

Fitting and Evaluation: This term means an examination for the proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.

B435.0117

All Options

Full-time: This term means:

You are not a Part-Time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employer in Your Eligible class (but not less than 30 hours per week), at:

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

B435.0145

All Options

High Index Lenses: This term means material that is used to create thinner lenses than normal plastic. The material does not contain the impact-resistant qualities of polycarbonate.

B435.0120

All Options

High Myopia: Refractive error greater than plus or minus 10.00 diopters of correction; best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with contact lenses.

B435.0121

All Options

Incurred, or Incurred Date: These terms mean: (1) the placing of an order for lenses, frames or contact lenses; or (2) the date on which such an order was placed.

B040.0860

All Options

Irregular Astigmatism: This term means greater than or equal to 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90 degrees, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles.

B435.0123

All Options

Keratoconus: This term means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area. Diagnosis confirmed by keratometric readings, or corneal topography best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses.

B435.0124

All Options

Lenticular Lenses: This term means mean high-powered lenses with the desired prescription power found only in the central portion. The outer portion has a front surface with a changing radius of curvature.

B040.0862

All Options

Low Vision: This term means a partial loss of vision; a loss of acuity or sharpness or a loss of side/peripheral vision; and that the Covered Person's most favorable corrected visual acuity is 20/70 or worse in one or both eyes.

B435.1046

All Options

Low Vision Supplemental Care: This term means subsequent Low Vision therapy, when visually necessary or appropriate.

B435.1047

All Options

Low Vision Supplementary Testing: This term means a Low Vision analysis and diagnosis. The analysis and diagnosis includes: (a) a comprehensive examination of visual functions; and (b) the prescription of corrective eyewear or vision aids, when required.

B435.1048

All Options

Mirror and Ski Coating: This term means a thin deposit of appropriate material to the front surface of a lens, causing a portion of the light striking the lens to reflect directly from the front surface.

B435.0125

All Options

Non-Preferred Provider: This term means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that is not under contract, directly or indirectly, with VSP as a Preferred Provider.

B435.0692

All Options

Orthoptics: This term means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

B040.0865

All Options

Oversize Lenses: This term means larger than a standard lens blank, to accommodate prescriptions.

B040.0866

All Options

Payment Limit: This term means the maximum amount this Certificate pays for covered services and supplies during a specified Benefit Period.

B435.0128

All Options

Payment Rate: This term means the percentage rate that this Certificate pays for covered services and supplies.

B435.0129

All Options

Photochromic Lenses: This term means lenses which change color with the intensity of sunlight.

B040.0870

All Options

Plano Lenses: This term means lenses which have no refractive power (lenses with less than a greater than or equal to .38 diopter power).

B435.0130

All Options

Polarized/Laminated Lenses: This term means lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

B435.0131

All Options

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

B435.0132

All Options

Polycarbonate Lenses: This term means the highest impact-resistant lens material available. Its high-index properties result in lenses 20-25% thinner than regular plastic. This material is often used for safety and children's eyewear as well as for sports and cosmetic purposes.

B435.0133

All Options

Preferred Provider: This term means an optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has entered into a contract, directly or indirectly with VSP to provide vision care services and or Vision Materials to Covered Persons.

B435.0638

All Options

Progressive Multi-Focal Lenses: This term means lenses that have no line, but progresses from distance, to intermediate, to near vision.

B435.0135

All Options

Registered Reciprocal Beneficiaries: This term means an employee and his or her reciprocal beneficiary: (a) who have filed a Declaration of Reciprocal Beneficiary Relationship with the Director of Health of the State of Hawaii as provided in section 572C-5 of the Hawaii Revised Statutes; (b) the declaration has been registered by the Director; and (c) a certificate of reciprocal beneficiary relationship has been provided to each party named on the declaration.

B435.1984

All Options

Reciprocal Beneficiary: This term means an adult who is a party to a valid reciprocal beneficiary relationship and who meets the following requirements for such a relationship:

- Each of the parties must be at least eighteen years old.
- Neither of the parties can be married nor a party to another reciprocal beneficiary relationship.
- The parties must be legally prohibited from marrying one another under chapter 572 of the Hawaii Revised Statutes.
- Consent of either party to the reciprocal beneficiary relationship has not been obtained by force, duress, or fraud.
- Each of the parties must sign a Declaration of Reciprocal Beneficiary Relationship.

B435.1985

All Options

Scratch Resistant Coating: This term means a coating applied to spectacle lenses to increase the scratch resistance of the lens surface.

B435.0136

All Options

Spouse: This term means the person to whom You are legally married, or Your registered 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 registered domestic partner, civil union partner or equivalent was recorded.

B435.0517

All Options

Standard Frames: This term means frames valued up to the limit published by VSP which is given to Preferred Providers.

B435.0639

All Options

Standard Lenses: This term means regular glass or plastic lenses.

B435.0139

All Options

Tinted Lenses: This term means lenses which have an additional substance added to produce constant tint.

B040.0878

All Options

Ultraviolet Coating (UV): This term means a coating that blocks ultraviolet rays.

B435.0141

All Options

Vision Materials: This term means (1) Elective Contact Lenses; or (2) Standard Lenses, Standard Frames or a complete pair of eyeglasses (lenses and frames).

B435.0142

All Options

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

B435.0143

All Options

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

B435.0144

All Options

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

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

Your group Vision 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 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 and Qualified Domestic Relations Order

Federal law required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Vision 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.

Vision 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.

B435.0152

All Options

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 relevant 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 vision 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 vision or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;

- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional 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.

B435.0153

All Options

VISION INSURANCE COVERAGE SCHEDULE OF BENEFITS

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

B435.1131

All Options

Initial Election You may choose to be covered under one of the plans of vision expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B435.0151

All Options

Group Enrollment Period A group enrollment period is held each year from December 1st to December 31st. During this period, You may choose to enroll for vision insurance coverage under the Policy. In that case, coverage is scheduled to start on the date determined by Your Employer that next follows the date You enroll.

B435.0155

All Options

PPO Copayments	Examinations	$20.00
	Standard Frames and/or Standard Lenses	$20.00
	Necessary Contact Lenses	$20.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Non-PPO Cash Deductibles	Examinations	$20.00
	Standard Frames and/or Standard Lenses	$20.00
	Necessary Contact Lenses	$20.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Payment Rates	For Covered Charges	100%
	For Low Vision Supplementary Testing furnished by a Preferred Provider	100%
	For Low Vision Supplementary Testing furnished by a Non-Preferred Provider	100%
	For Low Vision Supplementary Care furnished by a Preferred Provider	75%
	For Low Vision Supplementary Care furnished by a Non-Preferred Provider	75%

B435.1134

All Options

Changes in Coverage Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective until the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change.

B435.1139

CERTIFICATE RIDER

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Services and Supplies Received from Participating Retail Chain Providers

Vision care services and supplies that are covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider may also be covered by the Certificate when such services and supplies are received from a Participating Retail Chain Provider, subject to the limitations and exclusions below.

If services and supplies are received from a Participating Retail Chain Provider, We pay benefits for covered charges, after the Copayment, as shown below:

SERVICES AND SUPPLIES	PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB	OTHER PARTICIPATING RETAIL CHAIN PROVIDERS
Eye Exam - one in any one calendar year Benefit Period.	Covered In Full.	Covered In Full.

B435.1387

All Options

Standard Lenses - one pair in any one calendar year Benefit Period.		
• Single Vision	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
• Bifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
• Trifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
• Lenticular	Not Available.	Covered In Full. (Not all lens types may be available at all locations.)
Lens Options - once in any one calendar year Benefit Period.	Covered In Full. (Not all lens options may be available at all locations.)	Covered In Full. (Not all lens options may be available at all locations.)

B435.0668

All Options

SERVICES AND SUPPLIES	PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB	OTHER PARTICIPATING RETAIL CHAIN PROVIDERS
Standard Frames - one set in any one calendar year Benefit Period.	Covered In Full up to $70.00. No discount available on charges in excess of the benefit amount.	Covered In Full up to $130.00.

B435.1388

All Options

Elective Contact Lenses - one pair in any one calendar year Benefit Period.		
• Contact Lens (Materials Only)	Covered In Full up to $130.00.	Covered In Full up to $130.00.

B435.0672

All Options

LIMITATIONS

- Limitations and exclusions of benefits described in the Certificate for VSP Preferred Providers shall also apply to services and supplies received from Participating Retail Chain Provider Providers.
- If a service or supply is not covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by the Certificate when received from a Participating Retail Chain Provider.
- Services and supplies received from a Participating Retail Chain Provider are in lieu of services and supplies received from a VSP Preferred Provider or a Non-Preferred Provider. Membership may be required in order to access benefits through a Participating Retail Chain Provider. Membership fees are not covered under the Certificate.

B435.1160

All Options

EXCLUSIONS

- We do not cover charges for:
  - Medically Necessary Contact Lenses.
  - Safety Glasses.
  - Interim Benefits.
  - Primary Eye Care.
  - Diabetic Eye Care Plus Program.

B435.1161

DEFINITIONS

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Participating Retail Chain Provider: This term means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this rider. Not all Participating Retail Chain Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at (877) 814-8970 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Certificate.

Copayment: This term means a charge, expressed as a fixed dollar amount, required to be paid by, or on behalf of, a Covered Person to a Preferred Provider or a Participating Retail Chain Provider at the time covered vision services or supplies are received.

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

B435.0691

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry. **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B601.0246

GC-A-DP-21-CA

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