

Managed DentalGuard Group Benefit Plan

Prepared For:

**G&A PARTNERS
CLASS 0001 0004 0007 0010
DENTAL**

Managed DentalGuard, Inc.

a wholly owned subsidiary of Guardian

This Evidence of Coverage is intended to explain the benefits provided by this plan. It does not constitute the Group Contract. Your rights and benefits are determined in accordance with the provisions of the Group Contract, and your coverage is effective only if you are eligible for coverage and remain covered in accordance with its terms.

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CERTIFICATE OF COVERAGE

Managed DentalGuard, Inc.

14643 Dallas Parkway, Suite 100
Dallas, Texas 75254
1-888-618-2016

We, Managed DentalGuard, Inc, certify that the *employee* named below is entitled to the benefits provided by MDG described in this form, provided the eligibility and effective date requirements of the *plan* are satisfied.

Group Policy No.	Form No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above *plan* or under any other plan providing similar or identical benefits issued to the *planholder* by MDG.



Ray Marra
Vice President, Group Products
Managed DentalGuard

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call MDG's toll-free telephone number for information or to make a complaint at:

1-888-618-2016

You may contact the Texas Department of Insurance on companies, coverages, rights, or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

ATTACH THIS NOTICE TO YOUR CERTIFICATE.
This notice is for information only and does not become a part or condition of the attached document.

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AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Guardian's para informacion o para someter una queja al:

1-888-618-2016

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas al:

P.O. Box 149104
Austin, TX 78714-9104
FAX # (512) 475-1771

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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GENERAL PROVISIONS

As used in this booklet:

"Employer" means the *employer* or other entity who purchased this *plan*.

"Member" means an *employee* or a *dependent* covered by this *plan*.

"Our," "MDG," "us" and "we" mean Managed DentalGuard, Inc.

"Plan" means the MDG *plan* of group dental benefits purchased by your *employer*.

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

Limitation of Authority

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

No change in this *plan* shall be valid unless evidenced by: (a) an endorsement or rider to this *plan* signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of MDG; or (b) by an amendment to this *plan* signed by the *planholder* and one of the listed officers of MDG.

Incontestability

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

A group certificate may only be contested because of fraud or intentional misrepresentation of material fact on the enrollment application.

We may increase the premium charge to an appropriate level if we determine that the *employee* made a material misrepresentation of health status on the application. We must provide the *planholder* 31 days prior written notice of any premium rate change.

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Enrollment Procedures

You and your *dependents* may enroll for dental coverage by: (a) filling out and signing MDG's enrollment form and any additional material required by your *employer*; and (b) returning the enrollment material to your *employer*. Your *employer* will forward these materials to MDG. After your enrollment material has been received by MDG, you or your *dependents* need only contact that *member's* selected and assigned *primary care dentist's* office to obtain services.

MDG will issue you and each of your *dependents*, either directly or through your *employer's* representative, an MDG ID card. The ID card will show the *member's* name and the name, address and telephone number of his or her selected and assigned *primary care dentist* (PCD).

Open Enrollment Period If you do not enroll for dental coverage under this *plan* within 30 days of becoming eligible, *you* must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every 12 months after this *plan's* effective date, or at time intervals mutually agreed upon by your *employer* and MDG.

If, after initial enrollment, you or one of your *dependents* disenroll from the *plan* before the open enrollment period, the *member* may not re-enroll until the next open enrollment period.

When Your Coverage Starts Your coverage starts on the date shown on the face page of this *plan* if you are enrolled when the *plan* starts. If you are not enrolled on this date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by MDG; or (b) the first day of the month after the end of any waiting period your *employer* may require.

When Your Dependent Coverage Starts Except as stated below, your *dependents* will be eligible for coverage on the later of: (a) the day you are eligible for coverage; or (b) the first day of the month following the date on which you acquire such *dependent*.

If your *dependent* is a newborn child, his or her coverage begins on the date of birth. If your *dependent* is: (a) a stepchild; or (b) a foster child, coverage begins on the date that child begins to reside in your home. If the *dependent* is an adopted child, coverage begins on the date that the child is subject to a legal suit for adoption. If a newborn child, adopted child or foster child becomes covered under this plan, you must complete enrollment materials for such child within 30 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 30 days.

When Coverage Ends Subject to any continuation of coverage which may be available to you or your *dependents*, coverage under this *plan* ends when your *employer's* coverage terminates. Your and your *dependents'* coverage also ends on the first to occur of:

- (1) The end of the period for which you have made your last premium payment, if you are required to pay any part of this *plan*.
- (2) The end of the month in which a *member* is no longer eligible for coverage under this *plan*.
- (3) The end of the month in which your *dependent* is no longer a *dependent* as defined in this *plan*.
- (4) The date on which you or your *dependent* no longer reside or work in the *service area*.
- (5) The end of the month during which your *employer* receives written notice from you requesting termination of coverage for you or your *dependents*, or on such later date as *you* may request by the notice.
- (6) The date of a *member's* entry into active military duty. But, coverage will not end if the *member's* duty is temporary. "Temporary" means duty of 31 days or less.

- (7) 30 days after MDG sends written notice to a *member* advising that his or her coverage will end because the member has: (a) knowingly given false information in writing on his or her enrollment form; or (b) misused his or her ID card or other documents provided to obtain benefits available under this *plan*; or (c) otherwise acted in an unlawful or fraudulent manner regarding *plan* services and benefits; or
- (8) 30 days after MDG sends written notice to a *member*, where MDG has: (a) addressed the failure of the member and his or her PCD to establish a satisfactory patient-dentist relationship; (b) offered the member the opportunity to select another PCD; and (c) described the changes necessary to avoid termination.

**Extended Dental
Expense Benefits**

If your or your dependent's coverage ends, we extend dental expense benefits for the member under this plan as explained below.

We only extend benefits for covered services if the procedure(s) are: (a) started before the member's coverage ends; and (b) are completed within 90 days after the date his or her coverage ends. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the teeth are banded. Orthodontic treatment is started when the impressions are taken. Root canal is started when the pulp chamber is opened.

The extension of benefits ends on the first to occur of: (a) 90 days after the member's coverage ends; or (b) the date he or she becomes covered under another plan which provides coverage for similar dental procedures. But, if the plan which succeeds this plan excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the member's coverage ends.

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

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YOUR CONTINUATION RIGHTS

You and your dependents may be eligible to retain coverage under this *plan* during any Continuation of Coverage period or election period, necessary for your *employer's* compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for members, provided the *employer* continues to certify the eligibility of the member and the monthly premiums for COBRA coverage for the member continue to be paid by or through your *employer* pursuant to this *plan*.

An Important Notice About Continuation Rights

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

Federal Continuation Rights

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

This section applies to dental benefits only. In this section, these coverages are referred to as "group dental benefits."

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

If Your Group Dental Benefits End If your group dental benefits end due to termination of employment or reduction of hours, you may elect to continue such benefits for up to 18 months if: (a) you were not terminated due to gross misconduct; (b) you are not covered for benefits from any other group *plan* at the time your group dental benefits under this *plan* would otherwise end; and (c) you are not entitled to Medicare.

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

Extra Continuation For Disabled Qualified Continuees If a qualified continuee is determined to be disabled under Title XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to his or her 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.

Federal Continuation Rights (Cont.)

To elect the extra 11 months of continuation, the qualified continuee 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; and (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your *employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends."

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

If You Die While Covered If you die while covered, any qualified continuee 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 Your Marriage Ends If your marriage ends due to legal divorce or legal separation, any qualified continuee 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'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. But, such dependent must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends."

Concurrent Continuations If a dependent elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) your 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: (a) the dependent becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (b) 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.

The Qualified Continuee's Responsibilities A person eligible for continuation under this section must notify your *employer*, in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of dependent eligibility, as defined in this *plan*, of a dependent.

Such notice must be given to your *employer* within 60 days of either of these events.

Your Employer's Responsibilities Your *employer* must notify the qualified continuee, in writing, of: (a) his or her right to continue this *plan's* group 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.

Federal Continuation Rights (Cont.)

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer*, in writing, of your legal divorce or legal separation from your spouse, or the loss of dependent eligibility of a dependent.

Your Employer's Liability Election Of Continuation

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

Election Of Continuation

To continue his or her group dental benefits, the qualified continuee 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 continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's premium in a timely manner.

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

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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 *plan* on a regular basis. It includes any amount that would have been paid by your *employer*. Except as explained in the "Extra Continuation for Disabled Qualified Continuees," your *employer* may also require an additional charge of 2% of the total premium charge.

If the qualified continuee: (a) fails to give your *employer* notice of his or her intent to continue; or (b) fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace In Payment of Premiums

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

When Continuation Ends

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

- (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 the group dental benefits would otherwise end;

Federal Continuation Rights (Cont.)

- (b) with respect to a disabled qualified continuee 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 the group health benefits would otherwise end; 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 final determination is made that a disabled qualified continuee 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 the group dental benefits would otherwise end;
- (d) with respect to a dependent whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
- (e) the date the *plan* ends;
- (f) the end of the period for which the last premium payment is made;
- (g) the date he or she becomes covered under any other group dental *plan* which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or
- (h) the date he or she becomes entitled to Medicare.

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DENTAL BENEFITS PLAN

This *plan* will cover many of the dental expenses incurred by you and those of your dependents who are covered for dental benefits under this *plan*. MDG decides: (a) the requirements for benefits to be paid; and (b) what benefits are to be paid by this *plan*. We also interpret how the *plan* is to be administered. What we cover and the terms of coverage are explained below. But, decisions made by MDG may be modified or reversed by a court or regulatory agency with appropriate jurisdiction. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

Managed DentalGuard -This *Plan's* Dental Coverage Organization

Managed DentalGuard This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires members to seek dental care from participating dentists that belong to the Managed DentalGuard network (MDG network).

The MDG network is made up of participating dentists in a member's service area. A "participating dentist" is a *dentist* that has a participation agreement in force with us.

When a member enrolls in this *plan*, he or she will get information about MDG's current participating general dentists. Each member must select a primary care *dentist* from this list of participating general dentists. This PCD will coordinate all of the member's dental care covered by this *plan*. After enrollment, a member will receive a MDG ID card. A member must present this ID card when he or she goes to his or her PCD.

All dental services covered by this *plan* must be coordinated by the PCD whom the member selects and is assigned to upon enrolling in this *plan*. What we cover is based on all the terms of this *plan*. Read this booklet carefully for specific benefit levels, payment rates, payment limits and patient charges.

You can call the MDG Member Services Department if you have any questions after reading this booklet.

Choice of Dentists A member may select any available participating general *dentist* as his or her PCD. A request to change PCDs must be made to MDG. Any such change will be effective the first day of the month following approval. MDG may require up to 30 days to process and approve any such request. All fees and patient charges due to the member's current PCD must be paid in full prior to such transfer.

MDG compensates its participating general dentists through a capitation agreement by which they are paid a fixed amount of money each month based upon the number of members that select them as their PCD.

Managed DentalGuard -This *Plan's* Dental Coverage Organization (Cont.)

MDG may also make supplemental payments on a limited number of specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the participating general *dentist* receives from MDG. The *dentist* also receives compensation from *plan* members who may pay an office visit charge for each office visit and a defined patient charge for specific dental services. The schedule of patient charges is shown in the Covered Dental Services And Patient Charges section of this booklet.

Changes in Dentist Participation

We may have to reassign you to a different participating *dentist* if: (a) the *dentist* you have chosen is no longer a participating *dentist* in the MDG network; or (b) MDG takes an administrative action which impacts his or her participation in the network. If this becomes necessary, you will have the opportunity to choose another participating *dentist*. If you have a dental service in progress at the time of the reassignment, we will, at our option and subject to applicable law, either: (a) arrange for completion of the services by the original dentist; or (b) make reasonable and appropriate arrangements for another participating *dentist* to complete the service. If a member has "special circumstances" as defined in Article 20A.18(c) of the Texas Insurance Code, a member may be eligible for up to 90 days of continuing treatment from such participating *dentist* after his or her effective date of termination.

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Specialty Referrals

A member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a participating specialty care *dentist*. MDG 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 process described below.

MDG compensates its participating specialty care dentists the difference between their contracted fee and the patient charge given in the Covered Dental Services And Patient Charges section. This is the only form of compensation that participating specialty care dentists receive from MDG.

ALL SPECIALTY REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY MDG; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY MDG IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty services to be covered by this *plan*, the referral process stated below must be followed:

- (1) A member's PCD must coordinate all dental care.
- (2) When the care of a participating specialty care *dentist* is required, the PCD must contact MDG and request authorization.
- (3) If the PCD's request for specialty referral is approved, MDG will notify the member. He or she will be instructed to contact the participating specialty care *dentist* to schedule an appointment.

Managed DentalGuard -This *Plan's* Dental Coverage Organization (Cont.)

- (4) 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. (See **Appeal of Adverse Determination** , below, under **Complaint and Appeal Procedures** .)
- (5) If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.
- (6) A member who receives authorized specialty services must pay all applicable patient charges associated with the services provided.

When specialty dental care is authorized by MDG, a member will be referred to a participating specialty care *dentist* for treatment. The MDG network includes participating specialty care dentists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the member's service area. If there is no participating specialty care *dentist* in the member's service area, MDG will refer the member to a non-participating specialty care *dentist* of our choice. In no event will MDG pay for dental care provided to a member by a specialty care *dentist* not pre-authorized by MDG to provide such services.

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Emergency Dental Services

The MDG network also provides for emergency dental services 24 hours a day, 7 days a week, to all *members*. A *member* should contact his or her selected PCD, who will arrange for such care.

A *member* may require emergency dental services when he or she is unable to obtain services from his or her PCD. When emergency dental services are provided by a dentist other than the *member's* PCD, and without referral by the PCD or authorization by MDG, coverage is limited to palliative treatment (code 9110) only. The *member* must submit to MDG: (a) the bill incurred as a result of the emergency; (b) evidence of payment; and (c) a brief explanation of the emergency. This should be done within 60 days or as soon as reasonably possible. MDG will reimburse the member for the cost of the emergency dental services, less the applicable patient charge.

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Complaint and Appeal Procedures

Complaint Overview *Members* are entitled: (a) to have any complaint reviewed by MDG; and (b) to be provided with a resolution in a timely manner. MDG reviews each complaint in an objective, nonbiased manner and considers reaching a timely resolution a top priority.

Complaint and Appeal Procedures (Cont.)

"Complaint" means any dissatisfaction expressed by a complainant orally or in writing to the health maintenance organization with any aspect of the health maintenance organization's operation, including but not limited to dissatisfaction with plan administration; procedures related to review or appeal of an adverse determination; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions, expressed by a complainant. The term does not include a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the enrollee and does not include a provider's or enrollee's oral or written dissatisfaction or disagreement with an adverse determination.

Complaint Process *Members* make their concerns known by: (a) calling the MDG Member Services Department, using the toll-free telephone number; or (b) directly contacting MDG in writing.

A *Member* Service Representative logs each telephone call in the *member's* file. If a *member's* complaint regards: (a) *plan* administration; (b) procedures related to review or appeal of an adverse determination; (c) the denial, reduction or termination of a service; (d) the way a service is provided; or (e) disenrollment decisions, the *member* will be sent a letter and a complaint form to complete if he or she desires additional review. If the member does not return the completed complaint form within 15 days, he or she will receive a second letter. If MDG does not receive a response to the second letter, the *member's* file will be closed unless the *member* later asks in writing for further review.

On receipt of a written complaint or the complaint form, MDG will acknowledge the complaint within 5 business days. MDG will review and resolve the written complaint within 30 calendar days from the date of receipt, based upon objective evaluation of information gathered by MDG. Any quality of care issue will be reviewed with: (a) the Dental Director; and, if needed, (b) the Vice President of Network Management; and (c) legal counsel.

The *member* will receive a resolution letter, explaining: (a) the review process; and (b) the outcome of the review. The letter may include: (a) treatment plans and procedures; (b) clinical findings; (c) *plan* guidelines; (d) benefit information; and (e) contractual reasons for the resolution, as appropriate. A copy of the *plan's* appeal process will be enclosed with each resolution letter in case the *member* elects to have his or her complaint re-evaluated. In addition, information on how to contact the Department of Insurance for additional assistance will be noted in the resolution letter.

The Complaint Committee And The Peer Review Committee Complaints may be referred to the Complaint Committee or the Peer Review Committee for review and resolution. The role of the Committees is to review complaints, on a case by case basis, when the nature of the complaint requires Committee participation and decision to reach resolution. Once the matter has been resolved, the *member* will receive a written response explaining the resolution.

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

Complaint and Appeal Procedures (Cont.)

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

This Committee will meet within 30 days of the date the written request for appeal is received. But, more time will be permitted as necessary for extraordinary circumstances. The Committee is composed of an equal number of:

- a) Representative(s) from MDG;
- b) Representative(s) selected from Participating General Dentists;
- c) Representative(s) selected from Participating Specialty Care Dentists (if the complaint concerns specialty care); and
- d) Representative(s) selected from Plan Members.

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

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

Within 5 business days from the date of receipt of the written request for an appeal, the *member* will be sent written notice: (a) acknowledging the date the appeal was received; and (b) giving the date and location of the Committee meeting. The *member* will also be advised that: (a) he or she may appear in person before the Committee; or through a representative, if the *member* is a minor or disabled; or (b) address a written appeal to the Committee; and (c) may also bring any person to the Committee meeting. But, the participation of such person is subject to the Complaint Appeal Committee's guidelines. The *member* has the right to present: (a) written or oral information; and (b) alternative expert testimony. He or she also has the right to question the persons responsible for making the prior determination that resulted in the appeal.

The Committee will meet within the *member's* county of residence or the county where he or she normally receives dental care, unless another site is agreeable to the *member*. MDG will make a good faith effort to meet the *member's* needs in selecting the site.

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

Not less than 5 business days prior to the Committee meeting, MDG will submit to the *member* any and all documentation to be presented to the Committee, including names of *dentists* and names of *plan member* representatives on the Committee.

Complaint and Appeal Procedures (Cont.)

The *member* will receive a written notice of resolution within 5 business days after the date of the Committee resolution. The resolution notice will include a written statement of: (a) the specific medical determination; (b) clinical basis; and (c) the contractual criteria used to reach the final decision. The notice will also prominently and clearly state the procedure for making a complaint to the Department of Insurance in a manner prescribed by the Commissioner.

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The *member* will pay for his or her own expenses relating to the Committee process. MDG will pay for its expenses relating to the Committee process. MDG will pay for the expenses of the representative(s) from MDG and representative(s) selected from *participating general dentists* and/or participating specialty care *dentists*.

Following the decision of the Committee, the *member* and MDG each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a *participating dentist*.

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

P. O. Box 149104
Austin, TX 78714-9104
Telephone: (800) 252-3439
Fax #(512) 475-1771

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

If a re-evaluation of an emergency complaint is requested, the complaint will be reviewed by a *participating general dentist* or a specialty care *dentist*, if appropriate. Such *dentist* will be one who: (a) has not previously reviewed the case; and (b) is of the same or similar training as typically manages the dental condition, procedure of treatment under review. The review will occur within one day of receipt of the complaint. The *member* may receive an oral response, followed by a written response within 3 days.

CGP-3-MDGGRTX

B850.0468

Appeal Of Adverse Determination Adverse Determination means: a determination by us or a utilization review agent that the health care services furnished or proposed to be furnished to a patient are not medically necessary or are not appropriate.

We shall permit any party whose appeal of an adverse determination is denied by us to seek review of that determination by an independent review organization assigned to the appeal as follows;

- (1) We shall provide to you, your designated representative or your *dentist* information on how to appeal the denial of an adverse determination to an independent review organization;
- (2) Such information must be provided by us to you, your designated representative or your *dentist* at the time of the denial of the appeal;

Complaint and Appeal Procedures (Cont.)

- (3) We shall provide to you, your designated representative or your *dentist* the prescribed form;
- (4) The form must be completed by you, your designated representative or your *dentist* and returned to us to begin the independent review process;
- (5) In life threatening situations, you, your designated representative or your *dentist* may contact us by telephone to request the review and provide the required information.

The appeal process does not prohibit you from pursuing other appropriate remedies, including injunctive relief, a declaratory judgment, or relief available under law, if the requirement of exhausting the process for appeal and review places your health in serious jeopardy.

CGP-3-MDGADV

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Covered Dental Services And Patient Charges - Plan 38M

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *PCD* selected by the *member*.

The *member* must pay the listed *patient charge*. The benefits we provide are subject to all of the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

These *patient charges* are only valid for covered services rendered by *participating dentists* in the State of Texas.

MDG Codes+	Description of Service	Patient Charge
Appointments and Diagnostic Services		
0120	Periodic oral evaluation	No Charge
0140	Limited oral evaluation - problem focused	No Charge
0150	Comprehensive oral evaluation	No Charge
0460	Pulp vitality tests	No Charge
0470	Diagnostic casts	No Charge
0999	Office Visit - during regular hours - participating general dentist only	\$5.00
9310	Consultation (by dentist other than practitioner providing treatment)	No Charge
9430	Office visit for observation - regular hours - no other service performed	No Charge
9440	Emergency office visit - after regularly scheduled office hours	\$50.00
Radiographs		
0210	Intraoral - complete series (including bitewings)	No Charge
0220	Intraoral - periapical - single film	No Charge
0230	Intraoral - periapical - each additional film	No Charge
0240	Intraoral - occlusal - each film	No Charge
0270	Bitewing - single film	No Charge
0272	Bitewings - two films	No Charge
0274	Bitewings - four films	No Charge
0330	Panoramic film	No Charge
Preventive & Space Maintenance		
1110	Prophylaxis - adult (first 2 services in any 12 month period)++	No Charge
1120	Prophylaxis - child (first 2 services in any 12 month period)++	No Charge
1999	Prophylaxis - adult or child, with or without fluoride (each additional service in same 12 month period)++	\$60.00
1201	Topical application of fluoride (including prophylaxis) - child (first 2 services in any 12 month period)++	No Charge

+ Other codes may be used to describe covered services.

++ The patient charges for codes 1110, 1120, 1201 and 1203 are limited to the first two services in any 12 month period. For each additional service in the same 12 month period, see code 1999 or 1204 for the applicable patient charge.

Covered Dental Services And Patient Charges - Plan 38M (Cont.)

MDG Codes+	Description of Service	Patient Charge
Preventive & Space Maintenance (Cont.)		
1203	Topical application of fluoride (prophylaxis not included) - child (first 2 services in any 12 month period)++	No Charge
1204	Topical application of fluoride (prophylaxis not included) - child (each additional service in same 12 month period)++	\$20.00
1310	Nutritional instruction for control of dental diseases	No Charge
1330	Oral hygiene instruction	No Charge
1351	Sealant - per tooth - molars only	\$10.00
9999	Sealant - per tooth - non-molars	\$35.00
1510	Space maintainer - fixed - unilateral	\$80.00
1515	Space maintainer - fixed - bilateral	\$80.00
1550	Recementation of space maintainer	\$10.00
Restorative		
2110	Amalgam - one surface - primary	No Charge
2120	Amalgam - two surfaces - primary	No Charge
2130	Amalgam - three surfaces - primary	No Charge
2131	Amalgam - four or more surfaces - primary	No Charge
2140	Amalgam - one surface - permanent	No Charge
2150	Amalgam - two surfaces - permanent	No Charge
2160	Amalgam - three surfaces - permanent	No Charge
2161	Amalgam - four or more surfaces - permanent	No Charge
2210	Silicate cement - per restoration	No Charge
2330	Resin/composite - one surface, anterior	No Charge
2331	Resin/composite - two surfaces, anterior	No Charge
2332	Resin/composite - three surfaces, anterior	No Charge
2335	Resin/composite - four or more surfaces or incisal angle, anterior	\$70.00
2336	Composite resin crown, anterior - primary	\$70.00
2380	Resin/composite - one surface, posterior - primary	\$30.00
2381	Resin/composite - two surfaces, posterior - primary	\$40.00
2382	Resin/composite - three or more surfaces, posterior - primary	\$50.00
2385	Resin/composite - one surface, posterior - permanent	\$30.00
2386	Resin/composite - two surfaces, posterior - permanent	\$40.00
2387	Resin/composite - three or more surfaces, posterior - permanent	\$50.00
Crown, Bridge & Other Cast Restorations		
2510	Inlay - metallic - one surface*#	\$225.00
2520	Inlay - metallic - two surfaces*#	\$230.00
2530	Inlay - metallic - three or more surfaces*#	\$240.00
2543	Onlay - metallic - three surfaces*#	\$250.00
2544	Onlay - metallic - four or more surfaces*#	\$260.00

+ Other codes may be used to describe covered services.

++ The patient charges for codes 1110, 1120, 1201 and 1203 are limited to the first two services in any 12 month period. For each additional service in the same 12 month period, see code 1999 or 1204 for the applicable patient charge.

* If high noble metal is used, there may be an additional patient charge for the high noble metal. The total of the patient charges for high noble metal plus the applicable dental lab service charges may not exceed the general dentist's actual lab bill for the service.

There is an additional dental lab service patient charge for these procedures. See code 6199 for the applicable patient charge.

Covered Dental Services And Patient Charges - Plan 38M (Cont.)

MDG Codes+	Description of Service	Patient Charge
Crown, Bridge & Other Cast Restorations (Cont.)		
2740	Crown - porcelain/ceramic substrate#	\$290.00
2750	Crown - porcelain fused to high noble metal*#	\$280.00
2751	Crown - porcelain fused to predominantly base metal#	\$210.00
2752	Crown - porcelain fused to noble metal#	\$270.00
2790	Crown - full cast high noble metal*#	\$280.00
2791	Crown - full cast predominantly base metal#	\$210.00
2792	Crown - full cast noble metal#	\$270.00
2810	Crown - 3/4 cast metallic*#	\$280.00
2999	Crown supporting existing partial denture - in addition to crown	\$125.00
6199	Dental lab service - per inlay, onlay crown or bridge unit	\$75.00
6210	Pontic - cast high noble metal*#	\$280.00
6211	Pontic - cast predominantly base metal#	\$210.00
6212	Pontic - cast noble metal#	\$270.00
6240	Pontic - porcelain fused to high noble metal*#	\$280.00
6241	Pontic - porcelain fused to predominantly base metal#	\$210.00
6242	Pontic - porcelain fused to noble metal#	\$270.00
6520	Inlay - abutment - metallic - two surfaces*#	\$230.00
6530	Inlay - abutment - metallic - three or more surfaces*#	\$240.00
6543	Onlay - abutment - metallic - three surfaces*#	\$250.00
6544	Onlay - abutment - metallic - four or more surfaces*#	\$260.00
6750	Crown - abutment - porcelain fused to high noble metal*#	\$280.00
6751	Crown - abutment - porcelain fused to predominantly base metal#	\$210.00
6752	Crown - abutment - porcelain fused to noble metal#	\$270.00
6780	Crown - abutment - metallic*#	\$280.00
6790	Crown - abutment - full cast high noble metal*#	\$280.00
6791	Crown - abutment - full cast predominantly base metal#	\$210.00
6792	Crown - abutment - full cast noble metal#	\$270.00
6999	Multiple crown and bridge unit treatment plan - per unit	\$125.00
Other Restorative Services		
2910	Recement inlay	\$20.00
2920	Recement crown	\$20.00
2930	Prefabricated stainless steel crown - primary tooth	\$70.00
2931	Prefabricated stainless steel crown - permanent tooth	\$70.00
2932	Prefabricated resin crown	\$110.00
2940	Sedative filling	\$5.00
2950	Core buildup, including any pins	\$110.00
2951	Pin retention - per tooth, in addition to restoration	\$10.00
2952	Cast post & core, in addition to crown	\$140.00
2954	Prefabricated post & core	\$110.00
2960	Labial veneer (laminate) - chairside	\$105.00

+ Other codes may be used to describe covered services.

* If high noble metal is used, there may be an additional *patient charge* for the high noble metal. The total of the *patient charges* for high noble metal plus the applicable dental lab service charges may not exceed the general dentist's actual lab bill for the service.

There is an additional dental lab service *patient charge* for these procedures. See code 6199 for the applicable *patient charge*.

Covered Dental Services And Patient Charges - Plan 38M (Cont.)

MDG Codes+	Description of Service	Patient Charge
Other Restorative Services (Cont.)		
6930	Recement bridge	\$20.00
6970	Cast post & core, in addition to abutment	\$140.00
6972	Prefabricated post & core, in addition to abutment	\$110.00
6973	Core buildup for abutment, including any pins	\$110.00
Endodontics		
3110, 3120	Pulp cap	No Charge
3220	Therapeutic pulpotomy	\$45.00
3310	Root canal - anterior	\$90.00
3320	Root canal - bicuspid	\$160.00
3330	Root canal - molar	\$230.00
3346	Root canal - retreatment - anterior	\$105.00
3347	Root canal - retreatment - bicuspid	\$195.00
3348	Root canal - retreatment - molar	\$280.00
3410	Apicoectomy/periradicular surgery - anterior	\$140.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	\$140.00
3425	Apicoectomy/periradicular surgery - molar - first root	\$140.00
3426	Apicoectomy/periradicular surgery - each additional root	\$70.00
3430	Retrograde filling - per root	\$30.00

+ Other codes may be used to describe covered services.

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MDG Codes+	Description of Service	Patient Charge
Periodontics		
4210	Gingivectomy or gingivoplasty - per quadrant	\$100.00
4211	Gingivectomy or gingivoplasty - per tooth	\$40.00
4220	Gingival curettage, surgical - per quadrant - by report	\$45.00
4240	Gingival flap procedure - including root planing - per quadrant	\$130.00
4249	Clinical crown lengthening - hard tissue	\$110.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	\$290.00
4270	Pedicle soft tissue graft procedure	\$165.00
4271	Free soft tissue graft procedure (including donor site surgery)	\$170.00
4341	Periodontal scaling & root planing - per quadrant	\$45.00
4355	Full mouth debridement to enable evaluation and diagnosis	\$40.00
4910	Periodontal maintenance procedures (following active therapy)	\$35.00
4920	Unscheduled dressing change (by other than treating dentist)	No Charge
4999	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	\$175.00
9951	Occlusal adjustment - limited - per visit	\$25.00

+ Other codes may be used to describe covered services.

Covered Dental Services and Patient Charges - Plan 38M (Cont.)

MDG Codes+	Description of Service	Patient Charge
Prosthodontics (Removable)		
5110, 5120	Complete denture (including routine post delivery care)##	\$260.00
5130, 5140	Immediate denture (including routine post delivery care)##	\$260.00
	Partial dentures (including routine post delivery care):	
5211, 5212	Resin base - including clasps, rests, teeth##	\$250.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth##	\$260.00
	Repairs and adjustments:	
5410, 5411, 5421, 5422	Denture adjustments###	\$15.00
5510, 5610	Repair denture base###	\$25.00
5520, 5640	Replace missing or broken teeth - per tooth###	\$25.00
5630	Repair or replace clasp###	\$35.00
5650	Add tooth to existing partial###	\$25.00
5660	Add clasp to existing partial###	\$35.00
5710, 5711, 5720, 5721	Rebase denture###	\$100.00
5730, 5731, 5740, 5741	Reline denture (chairside)###	\$85.00
5750, 5751, 5760, 5761	Reline denture (laboratory)###	\$100.00
5820, 5821	Interim partial denture (stayplate)	\$150.00
5850, 5851	Tissue conditioning	\$30.00
5899	Dental lab service each new complete, immediate or partial denture - per denture	\$165.00
5999	Dental lab service - denture repair, rebase or reline - per denture	\$35.00
Oral Surgery		
7110	Extraction - single tooth	No Charge
7120	Extraction - each additional tooth	No Charge
7130	Root removal - exposed roots	No Charge
7210	Surgical removal of erupted tooth	\$35.00
7220	Removal of impacted tooth - soft tissue	\$25.00
7230	Removal of impacted tooth - partially bony	\$60.00
7240	Removal of impacted tooth - completely bony	\$75.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$75.00
7250	Surgical removal of residual tooth roots (cutting procedure)	\$35.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$90.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	\$115.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$90.00
7285	Biopsy of oral tissue - hard	\$60.00
7286	Biopsy of oral tissue - soft	\$55.00
7310	Alveoplasty in conjunction with extractions - per quadrant	\$40.00

+ Other codes may be used to describe covered services.

There is an additional dental lab service patient charge for these procedures. See code 5899 for the applicable patient charge.

Covered Dental Services and Patient Charges - Plan 38M (Cont.)

There is an additional dental lab service patient charge for these procedures. See code 5999 for the applicable patient charge.

Covered Dental Services and Patient Charges - Plan 38M (Cont.)

MDG Codes+	Description of Service	Patient Charge
Oral Surgery (Cont.)		
7320	Alveoplasty not in conjunction with extractions - per quadrant	\$55.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm	\$95.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm	\$165.00
7470	Removal of exostosis - maxilla or mandible	\$130.00
7510	Incision & drainage of intraoral abscess	\$45.00
7960	Frenulectomy (separate procedure)	\$95.00
Miscellaneous Services		
9110	Palliative (emergency) treatment - per visit	No Charge
9215	Local anesthesia	No Charge
9972	External bleaching - per arch- take home bleaching only	\$165.00

+ Other codes may be used to describe covered services.

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MDG Codes+	Description of Service	Patient Charge
Orthodontics		
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: dependent child to age 18 (as determined by the <i>member's</i> age on the date of banding)	\$2285.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: employee, spouse and dependent child over age 18 (as determined by the <i>member's</i> age on the date of banding)	\$2285.00
8660	Orthodontic evaluation and consultation	\$100.00
8670	Periodic comprehensive orthodontic treatment visit	No Charge
8680	Orthodontic retention	\$415.00
8999	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos	\$150.00

+ Covered Services are subject to this *plan's* exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

* These Orthodontic *patient charges* are valid only for authorized services rendered by *participating orthodontic specialty care dentists* in the State of Texas.

CGP-3-MDGTXL3-A

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Additional Conditions on Covered Services

General Guidelines For Alternative Procedures	There may be a number of accepted methods of treating a specific dental condition. When a <i>member</i> selects an <i>alternative procedure</i> over the service recommended by the <i>PCD</i> , the <i>member</i> must pay the difference between the <i>PCD's</i> usual charges for the recommended service and the <i>alternative procedure</i> . He or she will also have to pay the applicable <i>patient charge</i> for the recommended service.
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Additional Conditions on Covered Services (Cont.)

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. If high noble metal is used, the *member* may pay an additional amount for the actual cost of the high noble metal, in addition to (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; plus (b) the applicable dental lab service charge. The total *patient charges* for high noble metal plus the applicable dental lab service charge may not exceed the actual lab bill for the service.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *member* with a treatment *plan* in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

Crowns, Bridges And Dentures

A crown is a covered service when it is recommended by the *PCD*. The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan*. The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by relining, rebase or repair. Construction of new dentures may not exceed one each in any 5 year period from the date of previous placement under the *plan*.

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for six months; and (b) does not include required future rebasing or relining procedures or a complete new denture.

Multiple Crown/Bridge Unit Treatment Fee

A *member's* approved treatment *plan* may include 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the *member* must pay both: (a) the usual crown or bridge *patient charge* for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Covered Dental Services And Patient Charges section.

Crown Supporting Existing Partial Denture

A crown may be: (a) placed under an existing partial denture; and (b) be customized to physically support the metal framework of the partial denture. In such case, the *member* must pay the *patient charge* for a crown supporting an existing partial denture. This charge is shown in the Covered Dental Services And Patient Charges section. This charge is in addition to the *patient charge* for the crown or bridge unit itself. The *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* must pay the *patient charge* for a multiple crown/bridge unit treatment *plan*.

Additional Conditions on Covered Services (Cont.)

Dental Lab Service Charge For certain covered services in which your PCD may incur a bill from a dental lab, a *patient charge* for dental lab services will be charged in addition to the *patient charge* for the service itself. The *participating general dentist* will collect the listed *patient charge* for the dental lab service when a *member* receives an inlay, onlay, crown, bridge, denture, denture repair, denture rebase or denture relines. For crowns and/or bridges, a separate dental lab service *patient charge* will apply to each unit of crown and/or bridge. For dentures, a separate dental lab service *patient charge* will apply to each arch (e.g. one dental lab service *patient charge* for an upper denture and another dental lab service *patient charge* for a lower denture).

CGP-3-MDGGGB

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Pediatric Specialty Services During a *PCD* visit, a *member* under age 6 may be unmanageable. In such case, the *member* may be referred to a *participating pediatric specialty care dentist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *PCD* for further services. Later referrals to the *participating pediatric specialty care dentist*, if any, must first be authorized by MDG. If a *member* receives services from a participating specialty care *dentist* after his or her 6th birthday, the *employee* will be responsible for the contracted fee arranged between the participating specialty care *dentist* and MDG. If the *member* sees a non-participating specialty care *dentist*, the *employee* will be responsible for that *dentist's* usual fees.

Second Opinion Consultation A *member* may wish to consult another *dentist* for a second opinion regarding services recommended or performed by: (a) his or her PCD; or (b) a participating specialty care *dentist* through an authorized referral. To have a second opinion consultation covered by MDG, you must call or write Member Services for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the *plan*.

A Member Services Representative will help *you* identify a *participating dentist* to perform the second opinion consultation. *You* may request a second opinion with a non-participating general *dentist* or specialty care *dentist*. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting *dentist*.

The *plan's* benefit for a second opinion consultation is limited to \$50.00. If a *participating dentist* is the consultant, there is no cost to *you*. If a *non-participating dentist* is the consultant, *you* must pay any portion of his or her fee over \$50.00.

Noble and High Noble Metals The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, *you* may pay an additional amount for the actual cost of the high noble metal, in addition to (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; plus (b) the applicable dental lab service charge. The total *patient charges* for high noble metal plus the applicable lab service charge will not exceed the actual lab bill for the service.

CGP-3-MDGGGTX-A

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Additional Conditions on Covered Services (Cont.)

Orthodontic Treatment This *plan* covers orthodontic services as shown in Covered Dental Services And Patient Charges. Coverage is limited to one course of treatment per *member*. Treatment must be: (a) preauthorized by MDG; and (b) performed by a participating orthodontic specialty care *dentist*.

The *plan* covers up to 24 months of comprehensive *orthodontic treatment*. If treatment beyond 24 months is necessary, *you* must pay an added charge for each added month of treatment, based on the participating orthodontic specialty care *dentist's* contracted fee.

Orthodontic services are not covered if comprehensive treatment begins before the member is eligible for benefits under the *plan*. If a *member's* coverage terminates after the fixed banding appliances are inserted, the participating orthodontic specialty care *dentist* may prorate his or her usual fee over the remaining months of treatment. The *member* is responsible for all payments to the participating orthodontic specialty care *dentist* for services after the termination date.

If a *member* transfers to another participating orthodontic specialty care *dentist* after comprehensive orthodontic treatment has been started, *you* must pay any added costs associated with: (a) the change in orthodontic specialty care *dentist*; and (b) subsequent treatment.

The covered service 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. *You* must pay for any additional fixed or removable appliances. The benefit for orthodontic retention covers: (a) any and all necessary fixed and removable appliances; and (b) related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited *orthodontic treatment* and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances made with: (a) clear; (b) ceramic; (c) white or other optional material; or (d) lingual brackets. *You* must pay any added costs for the use of optional materials.

If a *member* has orthodontic treatment associated with orthognathic surgery, the *plan* provides its standard orthodontic benefit. Orthognathic surgery is a non-covered procedure involving the surgical moving of teeth. *You* must pay any added charges related to: (a) the orthognathic surgery; and (b) the complexity of the orthodontic treatment. The added charges will be based on the participating orthodontic specialty care *dentist's* usual and customary charge.

CGP-3-MDGORTH-C

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**Limitations On
Benefits For
Specific Covered
Services**

We don't pay benefits in excess of any of the following limitations:

- Periodontal maintenance procedure - 2 services in any 12 month period. One periodontal maintenance procedure may be performed by a participating periodontal specialty care dentist if done within 3 to 6 months following completion of approved, active periodontal therapy by the participating periodontal specialty care dentist. Such therapy includes periodontal scaling and root planing or periodontal surgery.

Additional Conditions on Covered Services (Cont.)

- Gingival flap procedure (4240) or osseous surgery (4260, 4999) - one service per quadrant or area in any 3 year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one service per area in any 3 year period.
- Periodontal scaling and root planing - one service per quadrant in any 12 month period.
- Reline of a complete or partial denture - one per denture in any 12 month period.
- Rebase of a complete or partial denture - one per denture in any 12 month period.
- Second opinion consultation - when approved by MDG, up to \$50.00.

CGP-3-MDGLMTTX

B850.0521

Exclusions

We won't pay for:

- any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law. This will apply even if the member fails to claim his or her rights to such benefit.
- dental services performed in a hospital or related hospital fees, unless a member is unable to undergo dental treatment in an office setting due to a documented physical, mental or medical reason as determined by the member's physician or by the *dentist* providing care.
- any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.
- any oral surgery requiring the setting of a fracture or dislocation.
- dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- any treatment or *appliance*: (a) which, in the opinion of the participating *dentist*, is not necessary for maintaining or improving the member's dental health; or (b) which is solely for cosmetic purposes. This exclusion will not apply to take-home external bleaching services (9972).
- precision attachments, stress breakers, magnetic retention or overdenture attachments.
- the use of: (a) general anesthesia; (b) intramuscular sedation; (c) intravenous sedation; or (d) inhalation sedation, including but not limited to nitrous oxide.
- any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature.

Exclusions (Cont.)

- replacement of a lost, missing or stolen *appliance* or prosthesis or the fabrication of a spare *appliance* or prosthesis.
- any member request for: (a) specialty care services or treatment which can be routinely provided by the PCD; (b) or treatment by a specialist without referral from the PCD and MDG approval.
- treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- any restoration, service, *appliance* or *prosthetic device* used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons.
- any service, *appliance*, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- dental services received from any *dentist* other than the selected and assigned PCD, unless expressly authorized in writing by the *plan*. This will not apply to covered emergency dental services.
- cephalometric x-rays, except when performed as part of the *orthodontic treatment plan* and records for a covered course of comprehensive *orthodontic treatment*.
- treatment which requires the services of a prosthodontist.
- treatment which requires the services of a pediatric specialty care *dentist*, after the member's 6th birthday.
- consultations for non-covered services.
- any procedure not listed as a covered service.
- any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- inlays, onlays, crowns or fixed bridges started but not completed prior to the member's eligibility to receive benefits under this *plan*. (Inlays, onlays, crowns or fixed bridges are: (a) started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented.)
- root canal treatment started but not completed prior to the member's eligibility to receive benefits under this *plan*. (Root canal treatment is: (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.)
- inlays, onlays, crowns or fixed bridges started (as defined above) by a non-participating *dentist*. This will not apply to covered emergency dental services.

Exclusions (Cont.)

- dentures or *orthodontic treatment* started prior to the member's eligibility to receive benefits under this *plan*. (Dentures are started when the impressions are taken. *Orthodontic treatment* is started when the teeth are banded.)
- root canal treatment started (as defined above) by a non-participating *dentist*. This does not apply to covered 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 and associated incremental charges. Orthognathic surgery is a procedure which involves the surgical moving of teeth.
- procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- procedures, appliances or devices: (a) to guide minor tooth movement; or (b) 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.
- re-treatment of orthodontic cases, or changes in *orthodontic treatment* necessitated by any kind of accident.
- replacement or repair of orthodontic appliances damaged due to the neglect of the member.

CGP-3-MDGEXCTX-C

B850.0633

CONVERTING THIS GROUP DENTAL PLAN

Important Notice: This section applies only to dental expense coverages. In this section, these coverages are referred to as "group dental benefits."

If Your Group Dental Benefits End: If your group dental benefits end for any reason, *you* can obtain a converted policy. But *you* must have been covered by this *plan* for at least 3 consecutive months immediately prior to the date your group dental benefits end. The converted policy will cover *you* and those of your eligible *dependents* whose group dental benefits end.

If You Die While Covered: If *you* die while covered, after any applicable continuation period has ended, your then covered spouse can convert. The converted policy will cover the spouse and those of your *dependent* children whose group benefits end. If the spouse is not living, each *dependent* child whose group dental benefits end may convert for himself or herself.

If Your Marriage Ends: If your marriage ends by legal divorce or annulment, and if your former spouse is dependent on *you* for financial support, your former spouse can convert. The converted policy will cover your former spouse and those of your *dependent* children whose group dental benefits end.

When A Dependent Loses Eligibility: When a covered *dependent* stops being an eligible *dependent*, as defined in this *plan*, he or she may convert. The converted policy will only cover the *dependent* whose group benefits end.

How and When to Convert: To convert, the applicant must apply to Us in writing and pay the required premium. He or she has 31 days after his or her group dental benefits end to do this. We don't ask for proof of insurability. The converted policy will take effect on the date the applicant's group dental benefits end. If the applicant is a minor or incompetent, the person who cares for and supports the applicant may apply for him or her.

The Converted Plan: The applicant may convert to the individual dental insurance policy we normally issue for conversion at the time he or she applies. The policy will be renewable. The converted policy will comply with the laws of the State of Texas when he or she applies.

Restrictions:

- (1) A *member* can't convert if his or her group dental benefits end because *you* have failed to make the required payments.
- (2) A *member* can't convert if his or her discontinued coverage is replaced by similar coverage within 31 days.
- (3) A *member* can't convert if his or her coverage ends for any of the reasons listed under numbers (7) or (8) of the WHEN COVERAGE ENDS section of this booklet.

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

Alternative Procedure means a service other than that recommended by the *member's PCD*. But, in the opinion of the *PCD*, such procedure is also an acceptable treatment for the *member's* dental condition.

CGP-3-MDGD1

B850.0526

Certificate Of Coverage means this booklet issued to *you*, which summarizes the essential terms of this *plan*.

CGP-3-MDGD2

B850.0527

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

CGP-3-MDGD3

B850.0528

Dependent means a person listed on your enrollment form who is any of the following:

1. your legal spouse;
2. your dependent children who are under age 26.

The term "dependent child" as used in this plan includes any: (a) stepchild; (b) newborn child; (c) legally adopted child; (d) unmarried grandchild who is your or your spouse's dependent for federal income tax purposes at the time application for coverage of the grandchild is made; or (e) child for whom you are court-appointed legal guardian, if the child; (i) is not married; (ii) is a part of your household, and (iii) is primarily dependent on you for support and maintenance. The term also includes any child for whom a court-ordered decree requires you to provide dependent coverage, and any child who is the subject of a legal suit for adoption by the employee.

3. a mentally retarded or physically handicapped child who: (a) has reached the upper age limit of a dependent child; (b) is not married; (c) is not capable of self-sustaining work; and (d) depends primarily on you for support and maintenance. You must furnish proof of such lack of capacity and dependence to MDG within 31 days after the child reaches the limiting age, and each year after that, if requested by MDG.
4. your domestic partner, who may be treated as a spouse under this plan, subject to the conditions below.

In order for a domestic partner to be treated as a spouse under this plan, both you and your domestic partner must:

- a. be 18 years of age or older;
- b. be unmarried; constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;

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

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

Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the planholder. Once you submit a "Statement of Termination", you may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner will not be eligible for continuation of dental coverage as explained: (a) under the "Federal Continuation Rights" section; and (b) under any other continuation rights section of this Plan, unless you are also eligible for and elect continuation.

The term "dependent" does not include a person who is also covered as an employee for benefits under any dental plan, which your employer offers, including this one.

Emergency Dental Services	are limited to procedures administered in a <i>dentist's</i> office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, or acute infection that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed.
	CGP-3-MDGD5-TX B850.0535
Employee or You	means a person: (a) who meets your <i>employer's</i> eligibility requirements; and (b) for whom your <i>employer</i> makes monthly payments under this <i>plan</i> .
	CGP-3-MDGD6 B850.0536
Employer or Planholder	means your <i>employer</i> or other entity: (a) with whom or to whom this <i>plan</i> is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its <i>members</i> .
	CGP-3-MDGD7 B850.0537
Member	means <i>you</i> and any of your eligible <i>dependents</i> : (a) as defined under the eligibility requirements of this <i>plan</i> ; and (b) as determined by your <i>employer</i> , who are actually enrolled in and eligible to receive benefits under this <i>plan</i> .
	CGP-3-MDGD8 B850.0538
Non-Participating Dentist	means any <i>dentist</i> who is not under contract with MDG to provide dental services to <i>members</i> .
	CGP-3-MDG-DEF9 B850.0539
Participating Dentist	means a <i>dentist</i> under contract with MDG. This term includes any hygienist and technician recognized by the dental profession who assists and acts under the supervision of such <i>dentist</i> .
	CGP-3-MDGD10 B850.0540
Participating General Dentist	means a <i>dentist</i> under contract with MDG: (a) who is listed in MDG's directory of <i>participating dentists</i> as a general practice <i>dentist</i> ; and (b) who may be selected as a <i>PCD</i> by a <i>member</i> and assigned by MDG to provide or arrange for a <i>member's</i> dental services.
	CGP-3-MDGD11 B850.0541
Participating Specialty Care Dentist	means a <i>dentist</i> under contract with MDG as an: (a) <i>endodontist</i> ; (b) <i>pediatric specialty care dentist</i> ; (c) <i>periodontist</i> ; (d) <i>oral surgeon</i> ; or (e) <i>orthodontist</i> .
	CGP-3-MDGD12B-TX B850.0544
Patient Charge	means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this <i>plan</i> . Such amount is the patient's portion of the cost of covered dental services.
	CGP-3-MDGD13 B850.0545
Plan	means the MDG group <i>plan</i> for dental services described in this booklet.
	CGP-3-MDGD14 B850.0546

Primary Care Dentist(PCD) means a dental office location: (a) at which one or more *participating general dentists* provide *covered services* to members; and (b) which has been selected by a *member* and assigned by MDG to provide and arrange for his or her dental services.

CGP-3-MDGD15

B850.0547

Service Area means the geographic area in which MDG is licensed to provide dental services for *members* and includes. Austin, Bains, Bastrop, Bell, Blanco, Bosque, Brazoria, Brazos, Burleson, Burnet, Caldwell, Chambers, Collin, Colorado, Comal, Cooke, Dallas, Denton, El Paso, Ellis, Erath, Fannin, Fayette, Fort Bend, Galveston, Gonzales, Grayson, Grimes, Guadalupe, Harris, Hays, Henderson, Hill, Hood Hunt, Jack, Johnson, Kaufman, Kendall, Lampasas, Lee, Liberty, Llano, Madison, Matagorda, Milam, Montague, Montgomery, Navarro, Palo Pinto, Parker, Polk, Rockwall, San Jacinto, Somervell, Tarrant, Travis, Trinity, Van Zandt, Walker, Waller, Washington, Wharton, Williamson, and Wise counties.

CGP-3-MDGD16-TX

B850.1222

We, Us, Our And MDG mean Managed DentalGuard, Inc.

CGP-3-MDGD17-TX

B850.0549

COORDINATION OF BENEFITS

Applicability

This Coordination of Benefits provision applies when a *member* has dental coverage under more than one *plan*.

When a *member* has dental coverage from more than one *plan*, this *plan* coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated.

As used here:

"Plan" means any of the following that provides dental expense benefits or services:

- (1) group or blanket insurance plans;
- (2) group service or prepayment plans on a group basis;
- (3) union welfare plans, *employer* plans, *employee* benefits plans, trusteed labor and management plans, or other plans for members of a group; and
- (4) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other government program or coverage which we are not allowed to coordinate with by law. "Plan" also does not include blanket school accident-type coverage.

"This *plan* " means the part of this *plan* subject to this provision.

How This Provision Works: The Order Of Benefits

We apply this provision when a *member* is covered by more than one *plan*. When this happens we consider each *plan* separately when coordinating payments.

In applying this provision, one of the plans is called the primary *plan*. A secondary *plan* is one which is not a primary *plan*. The primary *plan* pays first, ignoring all other plans. If a *member* is covered by more than one secondary *plan*, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary *plan* may take into consideration the benefits of any other *plan* which, under the rules of this section, has its benefits determined before those of that secondary *plan*.

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

- (1) A *plan* that covers a *member* as an *employee* pays first, the *plan* that covers a *member* as a *dependent* pays second;

How This Provision Works: The Order of Benefits (Cont.)

- (2) Except for *dependent* children of separated or divorced parents, the following governs which *plan* pays first when the *member* is a *dependent* child of an *employee* :
 - (a) The *plan* that covers a dependent of an *employee* whose birthday falls earliest in the calendar year pays first. The *plan* that covers a dependent of an *employee* whose birthday falls later in the calendar year pays second. The *employee's* year of birth is ignored.
 - (b) If both parents have the same birthday, the benefits of the *plan* which covered the parent longer are determined before those of the other *plan*.
- (3) For a dependent child of separated or divorced parents, the following governs which *plan* pays first when the member is a dependent of an *employee*:
 - (a) When a court order makes one parent financially responsible for the health care expenses of the dependent child, then that parent's *plan* pays first;
 - (b) If there is no such court order, then the *plan* of the natural parent with custody pays before the *plan* of the stepparent with custody; and
 - (c) The *plan* of the stepparent with custody pays before the *plan* of the natural parent without custody.
- (4) A *plan* that covers a member as an active *employee* or as a dependent of such *employee* pays first. A *plan* that covers a person as a laid-off or retired *employee* or as a dependent of such *employee* pays second.

If the *plan* with which we're coordinating does not have a similar provision for such persons, then (4) will not apply.

If rules (1), (2), (3) and (4) don't determine which *plan* pays first, the *plan* that has covered the person for the longer time pays first.

To determine the length of time a member has been covered under a *plan*, two plans will be treated as one if the member was eligible under the second within 24 hours after the first *plan* ended.

The member's length of time covered under one *plan* is measured from his or her first date of coverage under the *plan*. If that date is not readily available, the date the member first became a member of the group will be used.

CGP-3-MDG-COB

B850.0550

How This Provision Works: Coordination of Benefits

Coordination With Another Pre-Paid Dental Plan

A member may also be covered under another pre-paid dental *plan* where members pay only a fixed payment amount for each covered service.

How This Provision Works: Coordination of Benefits (Cont.)

For a PCD's services, when the PCD participates under both pre-paid plans, the member will never be responsible for more than the MDG patient charge.

For participating specialty care dentists' services and emergency dental services within the service area, when this *plan* is primary, our benefits are paid without regard to the other coverage. When this *plan* is the secondary coverage, 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.

For emergency dental services outside the service area, when this *plan* is primary, this *plan's* benefits are paid without regard to the other coverage. When this *plan* is the secondary *plan*, this *plan* pays the balance of expenses not paid by the primary *plan*, up to this *plan's* usual benefit.

Coordination With An Indemnity Or PPO Dental Plan

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

For a PCD's services, when this *plan* is the primary *plan*, the PCD submits a claim to the secondary *plan* for the patient charge amount. Any payment made by the secondary *plan* must be deducted from the member's payment.

For a PCD's services, when this *plan* 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 credited against the patient charge, reducing the member's out-of-pocket expense.

For specialist dentists' services and emergency dental services within the service area, when this *plan* is the primary *plan*, our benefits are paid without regard to the other coverage. When this *plan* 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.

For emergency dental services outside the service area, when this *plan* is primary, this *plan's* benefits are paid without regard to the other coverage. When this *plan* is the secondary *plan*, this *plan* pays up to \$50.00 for such services not paid by the primary *plan*.

Our Right To Certain Information

In order to coordinate benefits, we need certain information. A member must supply us with as much of that information as he or she can. If he or she can't give us all the information we need, we have the right to get this information from any source. If another insurer needs information to apply its coordination provision, we have the right to give that insurer such information. If we give or get information under this section, we can't be held liable for such action except as required by law.

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

STATEMENT OF ERISA RIGHTS

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

- (a) Examine, without charge, all *plan* documents, including contracts, collective bargaining agreements and copies of all documents filed by the *plan* with the U.S. Department of Labor, such as detailed annual reports and *plan* descriptions. The documents may be examined at the *plan* Administrator's office and at other specified locations such as worksites and union halls.
- (b) Obtain copies of all *plan* documents and other *plan* information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
- (c) Receive a summary of the *plan's* annual financial report from the Plan Administrator (if such a report is required.)

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people, called "fiduciaries," who are responsible for the operation of your benefit *plan*. They have a duty to operate the *plan* prudently and in the interest of *plan* participants and beneficiaries. Your *employer* may not fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps you can take to enforce the above rights. For instance, you may file suit in a federal court if you request materials from the *plan* and do not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay you up to \$110.00 a day until you receive them (unless the materials were not sent because of reasons beyond the Administrator's control.) If your claim for benefits is denied in whole or in part, or ignored, you may file suit in a state or federal court. If *plan* fiduciaries misuse the *plan's* money, or discriminate against you for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If you lose, the court may order you to pay: for example, if it finds your claim is frivolous. If you have any questions about your *plan*, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

We agree to duly investigate and endeavor to resolve any and all complaints received from members with regard to the nature of professional services rendered. Any inquiries or complaints shall be made to us by writing or calling us at the address and telephone indicated in this booklet.

CGP-3-MDGER

B850.0810

TECHNICAL DENTAL TERMS

ABSCCESS	acute or chronic, localized inflammation, with a collection of pus, associated with tissue destruction and, frequently, swelling.
ABUTMENT	a tooth used to support a prosthesis.
ALVEOLAR	referring to the bone to which a tooth is attached.
ALVEOLOPLASTY	surgical procedure for recontouring alveolar structures, usually in preparation for a prosthesis.
AMALGAM	an alloy used in direct dental restorations.
ANALGESIA	loss of pain sensations without loss of consciousness.
ANESTHESIA	partial or total absence of sensation to stimuli.
ANTERIOR	refers to the teeth and tissues located towards the front of the mouth - maxillary and mandibular incisors and canines.
APEX	the tip or end of the root end of the tooth.
APICOECTOMY	amputation of the apex of a tooth.
BICUSPID	a premolar tooth; a tooth with two cusps.
BILATERAL	occurring on, or pertaining to, both sides.
BIOPSY	process of removing tissue for histologic evaluation.
BITEWING RADIOGRAPH	interproximal view radiograph of the coronal portion of the tooth.
BRIDGE	a fixed partial denture (fixed bridge) is a prosthetic replacement of one or more missing teeth cemented or attached to the abutment teeth.
CANAL	space inside the root portion of a tooth containing pulp tissue
CARIES	commonly used term for tooth decay.
CAVITY	decay in tooth caused by caries; also referred to as carious lesion.
CEPHALOMETRIC RADIOGRAPH	a radiographic head film utilized in the scientific study of the measurements of the head with relation to specific reference points.
COMPOSITE	a tooth-colored dental restorative material
CROWN	restoration covering or replacing the major part, or the whole of the clinical crown -(i.e., that portion of a tooth not covered by supporting tissues.)
CROWN LENGTHENING	a surgical procedure exposing more tooth for restorative purposes by apically positioning the gingival margin and removing supporting bone.

CYST	pathological cavity, containing fluid or soft matter.
DEBRIDEMENT	removal of subgingival and/or supragingival plaque and calculus which obstructs the ability to perform an evaluation.
DECAY	the lay term for carious lesions in a tooth; decomposition of tooth structure.
DENTURE	an artificial substitute for natural teeth and adjacent tissues.
DENTURE BASE	that part of a denture that makes contact with soft tissue and retains the artificial teeth.
DIAGNOSTIC CAST	plaster or stone model of teeth and adjoining tissues; also referred to as study model.
DISTAL	toward the back of the dental arch (or away from the midline).
ENDODONTIST	a dental specialist who limits his/her practice to treating disease and injuries of the pulp (root canal therapy) and associated periradicular conditions.
EVULSION	separation of the tooth from its socket due to trauma.
EXCISION	surgical removal of bone or tissue.
EXOSTOSIS	overgrowth of bone.
EXTRAORAL	outside the oral cavity.
FRENULECTOMY	excision of muscle fibers covered by a mucous membrane that attaches the cheek, lips and or tongue to associated dental mucosa.
	CGP-3-MDGTERMS B850.0554
GINGIVA	soft tissues overlying the crowns of unerupted teeth and encircling the necks of those that have erupted, serving as the supporting structure for sub-adjacent tissues.
GINGIVAL CURETTAGE	the surgical procedure of scraping or cleaning the walls of a gingival pocket.
GINGIVECTOMY	the excision or removal of gingiva.
GINGIVOPLASTY	surgical procedure to reshape gingiva to create a normal, functional form.
HEMISECTION	surgical separation of a multirrooted tooth so that one root and/or the overlaying portion of the crown can be surgically removed.
HISTOPATHOLOGY	the study of composition and function of tissues under pathological conditions.
IMMEDIATE DENTURE	removable prosthesis constructed for placement immediately after removal of remaining natural teeth.

Technical Dental Terms (Cont.)

IMPACTED TOOTH	an unerupted or partially erupted tooth that is positioned against another tooth, bone, or soft tissue so that complete eruption is unlikely.
IMPLANT	material inserted or grafted into tissue; dental implant - device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement
INCISAL ANGLE	one of the angles formed by the junction of the incisal and the mesial or distal surfaces of an anterior tooth.
INLAY	an intracoronal restoration; a dental restoration made outside of the oral cavity to correspond to the form of the prepared cavity, which is then cemented into the tooth.
INTERCEPTIVE ORTHODONTIC TREATMENT	an extension of preventive orthodontics that may include localized tooth movement in otherwise normal dentition.
INTERIM PARTIAL DENTURE	a provisional removable prosthesis designed for use over a limited period of time, after which it is to be replaced by a more definitive restoration.
INTRAORAL	inside the mouth.
LABIAL	pertaining to or around the lip.
LIMITED ORTHODONTIC TREATMENT	<i>orthodontic treatment</i> with a limited objective, not involving the entire dentition
LINGUAL	pertaining to or around the tongue.
MESIAL	toward the midline of the dental arch.
METALS, CLASSIFICATION OF	The noble metal classification system is defined on the basis of the percentage of noble metal content: high noble - Gold(Au), Palladium(Pd), and/or Platinum(Pt) greater than 60% (with at least 40% Au); noble - Gold(Au), Palladium(Pd), and/or Platinum(Pt) greater than 25%; and predominantly base - Gold(Au), Palladium(Pd), and/or Platinum(Pt) less than 25%.
MOLAR	teeth posterior to the premolars (bicuspid) on either side of the jaw; grinding teeth, having large crowns and broad chewing surfaces.
OCCLUSAL ADJUSTMENT, LIMITED	reshaping of the occlusal surfaces of teeth to create harmonious contact relationships between the upper and lower teeth; typically on a "per visit" basis.
OCCLUSAL RADIOGRAPH	an intraoral radiograph made with the film being held between the occluded teeth.
OCCLUSION	any contact between biting or chewing surfaces of maxillary (upper) and mandibular (lower) teeth.

Technical Dental Terms (Cont.)

ONLAY	a restoration made outside the oral cavity that replaces a cusp or cusps of the tooth, which is then cemented to the tooth.
ORAL SURGEON	a dental specialist whose practice is limited to the diagnosis, surgical and adjunctive treatment of diseases of the oral regions.
ORTHODONTIST	a dental specialist whose practice is limited to the treatment of malocclusion of the teeth
ORTHOGNATHIC	functional relationship of maxilla and mandible.
OVERDENTURE	<i>prosthetic device</i> that is supported by retained teeth roots.
PALLIATIVE	action that relieves pain but is not curative.
PANORAMIC RADIOGRAPH	an extraoral radiograph on which the maxilla and mandible are depicted on a single film.
PARTIAL DENTURE, REMOVABLE	a prosthetic replacement of one or more missing teeth on a framework that can be removed by the patient.
PEDIATRIC DENTIST	a dental specialist whose practice is limited to treatment of children
PERIAPICAL	the area surrounding the end of the tooth root.
PERIODONTAL	pertaining to the supporting and surrounding tissues of the teeth.
PERIODONTAL DISEASE	inflammatory process of the gingival tissues and/or periodontal membrane of the teeth, resulting in an abnormally deep gingival sulcus, possibly producing periodontal pockets and loss of supporting alveolar bone. CGP-3-MDGTERMS B850.0555
PERIODONTIST	a dental specialist whose practice is limited to the treatment of periodontal diseases.
PERIRADICULAR	surrounding a portion of the root of the tooth.
PONTIC	the term used for the artificial tooth on a fixed bridge.
POST	an elongated metallic projection fitted and cemented within the prepared root canal, serving to strengthen and retain restorative material and/or a crown restoration.
POSTERIOR	refers to teeth and tissues towards the back of the mouth (distal to the canines) - maxillary and mandibular premolars and molars.
PRECISION ATTACHMENT	interlocking device, one component of which is fixed to an abutment or abutments and the other is integrated into a fixed or removable prosthesis in order to stabilize and/or retain it.
PREMOLAR	see bicuspid.

Technical Dental Terms (Cont.)

PRIMARY DENTITION	the first set of teeth.
PROPHYLAXIS	scaling and polishing procedure performed to remove coronal plaque, calculus and stains.
PROSTHESIS, DENTAL	any device or <i>appliance</i> replacing one or more missing teeth and/or, if required, certain associated structures.
PROSTHODONTIST	a dental specialist whose practice is limited to the restoration of the natural teeth and/or the replacement of missing teeth with artificial substitutes.
PULP	the blood vessels and nerve tissue that occupies the pulp chamber of a tooth.
PULP CAP	procedure in which the exposed or nearly exposed pulp is covered with a protective dressing or cement to maintain pulp vitality and/or protect the pulp from additional <i>injury</i> .
PULP CHAMBER	the space within a tooth which contains the pulp.
PULPOTOMY	surgical removal of a portion of the pulp with the aim of maintaining the vitality of the remaining portion by means of an adequate dressing.
QUADRANT	one of the four equal sections into which the dental arches can be divided; begins at the midline of the arch and extends distally to the last tooth.
RADIOGRAPH	x-ray.
REBASE	process of refitting a denture by replacing the base material.
REIMPLANTATION, TOOTH	the return of a tooth to its alveolus.
RELINE	process of resurfacing the tissue side of a denture with new base material.
RETENTION	the phase of orthodontics used to stabilize teeth following comprehensive <i>orthodontic treatment</i> .
RETROGRADE FILLING	a method of sealing the root canal by preparing and filling it from the root apex.
ROOT	the anatomic portion of the tooth that is located in the alveolus (socket) where it is attached by the periodontal apparatus.
ROOT CANAL	the portion of the pulp cavity inside the root of a tooth; the chamber within the root of the tooth that contains the pulp.
ROOT CANAL THERAPY	the treatment of disease and injuries of the pulp and associated periradicular conditions.
ROOT PLANING	a procedure designed to remove microbial flora, bacterial toxins, calculus, and diseased tooth structure on the root surfaces and in the pocket.

Technical Dental Terms (Cont.)

SCALING	removal of plaque, calculus, and stain from teeth.
SPLINT	a device used to support, protect, or immobilize oral structures that have been loosened, replanted, fractured or traumatized.
STRESS BREAKER	that part of a tooth-borne and/or tissue-borne prosthesis designed to relieve the abutment teeth and their supporting tissues from harmful stresses.
STUDY MODEL	plaster or stone model of teeth and adjoining tissues; also referred to as diagnostic cast.
TEMPOROMANDIBULAR JOINT (TMJ)	the connecting hinge mechanism between the mandible (lower jaw) and base of the skull (temporal bone).
TISSUE CONDITIONING	material intended to be placed in contact with tissues, for a limited period, with the aim of assisting their return to healthy condition.
UNERUPTED	tooth/teeth that have not penetrated into the oral cavity.
UNILATERAL	one-sided; pertaining to or affecting but one side.
VENEER	in the construction of crowns or pontics, a layer of tooth-colored material, usually, but not limited to, composite, porcelain, ceramic or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention; also refers to a restoration that is cemented to the tooth.

CGP-3-MDGTERMS

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CERTIFICATE AMENDMENT

Certain provisions of the Dental Benefits Plan section of your Certificate of Coverage are amended as follows:

1. **The Covered Dental Services and Patient Charges Section**, the 3rd paragraph is hereby deleted and the following paragraph is added:

The patient charges listed in the Covered Dental Services and Patient Charges Section are only for covered services that are: (1) started and completed under this plan, and (2) rendered by participating dentists in the State of Texas.

2. **The Additional Conditions on Covered Services Section is amended by adding the following:**

Treatment in Progress: A member may choose to have a participating dentist complete an inlay, onlay, crown, fixed bridge, root canal, denture 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 plan. The member is responsible to identify, and transfer to, a participating dentist willing to complete the procedure at the patient charge described in this amendment.

Inlays, onlays, crowns, fixed bridges, or dentures which: (1) are listed in the Covered Dental Services and Patient Charges Section; and (2) were started but not completed prior to the member's eligibility to receive benefits under this plan have a patient charge equal to 85% of the participating general dentist's usual fee (there is no additional patient charge for high noble metal or dental lab service). Inlays, onlays, crowns or fixed bridges are: (a) started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented. Dentures are (1) started when the impressions are taken; and (2) completed when the denture is delivered to the patient.

Root canal treatment procedures which: (1) are listed in the Covered Dental Services and Patient Charges Section; and (2) were started but not completed prior to the member's eligibility to receive benefits under this plan have a patient charge equal to 85% of the participating general dentist's or participating endodontic specialty care dentist's usual fee. Root canal treatment is: (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.

Please refer to the Covered Dental Services and Patient Charges Section to determine if your plan covers orthodontic treatment. If it does, then this paragraph applies to your plan. Orthodontic treatment procedures which: (1) are listed in the Covered Dental Services and Patient Charges Section; and (2) were started but not completed prior to the member's eligibility to receive benefits under this plan have a patient charge equal to 85% of the participating orthodontic specialty care dentist's usual fee. Retention services are covered at the patient charge shown in the Covered Dental Services and Patient Charges Section only following a course of comprehensive orthodontic treatment started and completed under this plan. When comprehensive orthodontic treatment is started prior to the member's eligibility to receive benefits under this plan, the patient charge for orthodontic retention is equal to 85% of the participating orthodontic specialty care dentist's usual fee. Comprehensive orthodontic treatment is started when the teeth are banded.

3. The **Exclusions Section** is amended by deleting the following exclusions:

We won't pay for:

- inlays, onlays, crowns or fixed bridges started (as defined above) by a non-participating dentist. This will not apply to covered emergency dental services.
- root canal treatment started (as defined above) by a non-participating dentist. This does not apply to covered emergency dental services.

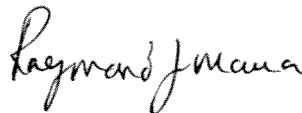
4. The **Exclusions Section** is amended by adding the following exclusion:

- We won't pay for inlays, onlays, crowns, fixed bridges or root canal treatment started (as defined) by a non-participating dentist while the member is covered under this plan. This does not apply to covered emergency dental services.

5. The **Complaint and Appeal Procedures** Section is amended as follows:

The second paragraph under **Re-Evaluation** is amended by deleting the following sentence:
"But, more time will be permitted as necessary for extraordinary circumstances."

Except as stated in this amendment, nothing contained in this amendment changes or affects any other terms of this Certificate of Coverage.



Ray Marra
Vice President, Group Products
Managed DentalGuard, Inc.

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

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

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

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

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

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Guardian is required to use or disclose your PHI :

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

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

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

Other Uses and Disclosures .

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

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

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- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How to Contact Us:

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

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457

B998.0054

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com

