ALL ELIGIBLE EMPLOYEES
00527280

Guardian

THE UNITED METHODIST CHURCH OF GREATER NEW JERSEY

Benefits Plan

Here you'll find information about your following employee benefit(s). Be sure to review the enclosed - it provides everything you need to sign up for your Guardian benefits.

- Dental

Find a Provider Online. It's easy.

- Search by: specialty, languages spoken, and more
- Side-by-side comparisons of provider information
- Get maps and driving direction
- Save your search criteria for easy access ...and much more

Go to www.GuardianAnytime.com. Click on "Find a Provider"

The Guardian Life Insurance Company of America, New York, NY 10004

Dental Plans

Option 1: With your **Managed Dental Care** plan, you enjoy negotiated discounts from our network dentists. You pay a fixed copay for each covered service. Out-of-network visits are not covered.
Option 2 or 3: With your **Buy Up or Base** plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are limited to our PPO fee schedule.

Your Dental Plan	Option 1: Managed Dental Care	Option 2: Buy Up		Option 3: Base	
Network	Managed DentalGuard	DentalGuard Preferred		DentalGuard Preferred	
Your premium	**$41.01**	**$121.02**		**$86.43**	
You and spouse	$81.99	$245.70		$175.68	
You and child(ren)	$112.53	$275.85		$198.03	
You, spouse and child(ren)	$145.11	$424.32		$304.17	
Calendar year deductible		*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Individual	No deductible	$50	$50	$50	$75
Family limit		3 per family		3 per family	
Waived for		Preventive	Preventive	Preventive	None
Charges covered for you (co-insurance)	*Network only*	*In-Network*	*Out-of-Network*	*In-Network*	*Out-of-Network*
Preventive Care	You pay a copay for each	100%	100%	100%	100%
Basic Care	covered procedure. See	80%	80%	90%	80%
Major Care	"Plan Details", for	50%	50%	40%	25%
Orthodontia	more information.	50%	50%	Not Covered (applies to all levels)	
Annual Maximum Benefit		$2000	$2000	$1000	$1000
Preventive Services Exempt from Maximum	Not Applicable	Yes		Yes	
Maximum Rollover	Maximum Rollover is not	Yes		Yes	
Rollover Threshold	applicable for this plan type.	$800		$500	
Rollover Amount		$400		$250	
Rollover In-network Amount		$600		$350	
Rollover Account Limit		$1500		$1000	
Lifetime Orthodontia Maximum	Not Applicable	$1000		Not Applicable	
Office visit copay	$5	None		None	
Dependent Age Limits	26	26		26	

YOUR GUARDIAN PLAN OFFERS:

If you enroll in Dental, you receive a Vision Access Plan at no additional charge. Visit any network doctor in your Access Plan and you'll receive discounts on exams, glasses, contact lens professional services and laser vision surgery.

Maximum rollover If a member submits at least one claim and stays under the claims threshold, a part of the unused maximum will be rolled over for use in future years.

Great selection of dentists convenient to you - yours is likely in our network!

Reliable claims payment four days on average

Find out if your dentist is in Guardian's network at www.GuardianAnytime.com

Let Guardian put its 30-plus years of dental benefits experience to work for you and your family.

Benefit information illustrated within this material reflects the plan covered by Guardian as of 01/22/2019

CATEGORY	PLAN DETAILS	Option 1: Managed Dental Care	Option 2: Buy Up		Option 3: Base	
		You Pay	*Plan pays (on average)*		*Plan pays (on average)*	
		Network only	*In-network*	*Out-of-network*	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	$0	100%	100%	100%	100%
	Frequency:	2 times in 12 months^	Once Every 6 Months		Once Every 6 Months	
	Fluoride Treatments	$0-12	100%	100%	100%	100%
	Limits:	No Age Limits	Under Age 19		Under Age 19	
	Oral Exams	$0	100%	100%	100%	100%
	Sealants (per tooth)	$14	100%	100%	100%	100%
	X-rays	$0	100%	100%	100%	100%
Basic Care	Anesthesia*	Restrictions Apply	80%	80%	90%	80%
	Fillings‡	$28-56	80%	80%	90%	80%
	Repair & Maintenance of Crowns, Bridges & Dentures	$18-230	80%	80%	90%	80%
	Simple Extractions	$35	80%	80%	90%	80%
Major Care	Bridges and Dentures	$580-675	50%	50%	40%	25%
	Dental Implants	Not Covered	50%	50%	40%	25%
	Inlays, Onlays, Veneers**	$250-420	50%	50%	40%	25%
	Perio Surgery	$188-410	50%	50%	40%	25%
	Periodontal Maintenance	$32	50%	50%	40%	25%
	Frequency:	2 times in 12 months^ (applies to all tiers) (Standard)	Once Every 6 Months		Once Every 6 Months	
	Root Canal	$260-400	50%	50%	40%	25%
	Scaling & Root Planing (per quadrant)	$30-50	50%	50%	40%	25%
	Single Crowns	$430	50%	50%	40%	25%
	Surgical Extractions	$110-240	50%	50%	40%	25%
Orthodontia	Orthodontia	$1,500-2,800	50%	50%	Not Covered	
	Limits:	Adults & Child(ren)	Child(ren)			
Cosmetic Care	Bleaching	$165	Not Covered (applies to all tiers)		Not Covered (applies to all tiers)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia - restrictions apply. ‡For PPO and or Indemnity members, Fillings-restrictions may apply to composite fillings. (^Additional cleanings are available for an additional co-pay).

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Please note: The plan details listed here are some of the most common services related to dental coverage. The co-insurance percentages for the PPO plan options correspond to the coverage categories of Preventive, Basic, Major and Orthodontia listed in the table above.

Some services may be paid under a different category than listed. The actual co-insurance shown reflects your plan's coverage.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.

This policy provides dental coverage only. This policy provides managed care dental benefits through a network of participating general dentists and specialty care dentists. Except for limited emergency services, benefits will be provided for services provided by the primary care dentist selected by the member. The member must pay the primary care dentist a patient charge/copayment for most covered services. No benefits will be paid for treatment by a specialist unless the patient is referred by his or her primary care dentist and the referral is approved under the policy. Only those services listed in the policy's schedule of benefits are covered. Certain services are subject to frequency or other periodic limitations. Where orthodontic benefits are specifically included, the policy provides for one course of comprehensive treatment per member. Unless specifically included, the Managed Dental Care policy does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed Dental Care policy. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The applicable Managed Dental Care documents are the final arbiter of coverage .See your Certificate for complete specifics of all Exclusions and Limitations. All products, unless otherwise noted, are underwritten by The Guardian Life. Insurance Company of America ("Guardian") or one of the following wholly-owned Guardian subsidiaries: Managed Dental Care (CA); First Commonwealth Insurance Company (IL); First Commonwealth Limited Health Services Corporation (IN); First Commonwealth Limited Health Services Corporation of Michigan (MI); First Commonwealth of Missouri, Inc. (MO) and Managed DentalGuard, Inc. (NJ, OH and TX). Any reference to a specific product type, including but not limited to "DHMO" or "Prepaid" is not intended to refer to a specific state license designation, but rather is merely intended to refer to a general product design. Such DHMO, or prepaid products, are licensed in the applicable jurisdiction. In addition, certain products are underwritten by Dominion Dental Services, Inc. (DC, DE, MD, PA and VA) and LIBERTY Dental Plan of Nevada, Inc. (NV). Please see the applicable policy forms for details. In the event of conflict between this brochure and the policy forms, the policy forms shall control.

For PPO and or Indemnity Special Limitation: Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.R3-DG2000

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Your Guardian VSP Vision Access Program

An eligible person can receive discounts on vision care services or supplies from a vision provider that is under contract with Vision Service Plan's (VSP) Preferred Provider Organization (PPO) network. The eligible person must pay the entire discounted fee directly to the VSP network doctor. Discounts are not available from providers who are not members of VSP's network.

Average Discounts

- Eye Exams: 20% off the VSP doctor's usual charge
- Frames, Standard Lenses and Lens Options: 20% off VSP doctor's usual charge, when a complete pair of prescription glasses is purchased.
- Contact Lens Professional Services: 15% off VSP doctor's usual charge for professional services. The contact lenses are not discounted.
- Laser Surgery: an average of 15% off the laser surgeon's usual charge or 5% off of any promotional price, if it is less than the usual discounted price

No ID cards are required, but the patient must notify the VSP network doctor that they have the Guardian VSP Access Plan at the time of service to receive their discount. Discounts are only available from the VSP network doctor that provided the eye exam to the patient within the last 12 months.

This is not insurance. The eligible person must pay the entire discounted fee directly to the VSP network doctor. There is no charge for the Discount Vision Access program. A person must be enrolled in a Guardian dental plan in order to be eligible for the Discount Vision Access program. When a person is no longer enrolled in a Guardian dental plan, access to the network discounts ends.

To find a VSP network doctor, visit www.guardiananytime.com or call VSP member services at 1-877-814-8970.

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MANAGED DENTALGUARD

CA, CO, FL, IL, IN, MI, MO, NJ, NY, and OH

FINE PRINT

(For MDG Plans U10G, U11G, U20G, U21G, U30G, U31G, U40G, U41G, U50G, U51G, U60G, U61G, U10M, U11M, U20M, U21M, U30M, U31M, U40M, U41M, U50M, U51M, U60M, and U61M)

Managed DentalGuard (Guardian, First Commonwealth, Managed Dental Care, Managed DentalGuard, MDG) (Us; We) combines broad dental coverage with a number of cost-saving features for you and your family. Many procedures are covered at no cost to you. There are no claim forms to complete, no deductibles and no yearly maximums.

Emergency Dental Services (Applicable in CA, CO, FL, NJ and OH only)
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 Primary Care Dentist (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. The Member should contact his or her PCD for a referral to another Dentist or contact Us for an authorization to obtain services from another Dentist. The Member must submit to Us: (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. We will reimburse the Member for the cost of covered emergency dental services, less the applicable Patient Charge(s).

When emergency dental services are provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us, coverage is limited to the benefit for palliative treatment (code D9110) only.

Emergency Dental Services (Applicable in IL, IN, MI, and MO only)
Emergency Dental Services means only covered, bona fide emergency services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling serious bleeding or severe discomfort, or to prevent the imminent loss of teeth. Services related to the initial emergency condition but not required specifically to relieve pain, discomfort, bleeding or swelling or to prevent imminent tooth loss, including services performed at the emergency visit and services performed at subsequent visits, are not considered emergency dental services.

A Member should contact his or her PCD who will arrange for Emergency Dental Services. All PCDs are required to have arrangements for Emergency Dental Services 24 hours a day, 7 days a week.

A Member may require Emergency Dental Services when he or she is unable to obtain services from his or her PCD. The Member should contact his or her PCD for a referral to another dentist or contact First Commonwealth's Member Services Department for an authorization to obtain services from another dentist. The Member must submit to First Commonwealth: (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 30 days or as soon as reasonably possible. First Commonwealth will reimburse the Member for the cost of Emergency Dental Services, less the applicable Patient Charge(s).

When Emergency Dental Services are provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by First Commonwealth, coverage is limited to the benefit for palliative treatment (code D9110) only.

Follow-up care, if needed, should be provided by the Member's PCD.

Emergency Dental Services (Applicable in NY only)
We provide for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. A Member should contact his or her selected and assigned PCD, who will make arrangements for such care. If the Member is unable to reach his or her PCD in an emergency during normal business hours, he or she must contact our Member Services Department for instructions. If the Member is not able to reach his or her PCD in an emergency after normal business hours, the Member may seek Emergency Dental Services from any dentist. Then, within 2 business days, he or she should call Guardian to advise of the emergency claim. The Member must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the

emergency; and (d) a description of the attempt to reach his or her PCD. This must be done within 90 days, or as soon as is reasonably possible. Guardian will reimburse the Member for 50% of the cost of the Emergency Dental Services.

General Guidelines For Alternative Procedures
There may be a number of accepted methods of treating a specific dental condition. When a Member selects an alternative procedure over the service recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended service and the alternative procedure. He or she will also have to pay the applicable Patient Charge for the recommended service.

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

When the Member selects an extraction as an alternative procedure to root canal therapy, the alternative procedure does not apply.

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

The Plan provides for the use of noble, high noble and base metals for inlays, onlays, crowns, and fixed bridges. When high noble metal is used, the Member will pay an additional amount for the actual cost of the high noble metal. In addition, the Member will pay the usual Patient Charge for the inlay, onlay, crown or fixed bridge. The total Patient Charges for the high noble metal 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 the treatment plan in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

General Guidelines For Alternative Treatment By The PCD
There may be a number of accepted methods for treating a specific dental condition. In all cases where there are more than one course of treatment available, a full disclosure of all the options must be given the Member before treatment begins. The PCD should present the Member with a written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the Member should pay, and to fully document informed consent.

- If any of the recommended alternate services are selected by the Member and not covered under the Plan, then the Member must pay the PCD's usual charge for the recommended alternate service.
- If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not an appropriate service for the condition being treated), then the PCD is not obliged to provide that treatment even if it is a covered service under the Plan.

Members can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the PCD or Participating Specialty Care Dentist.

Crowns, Bridges and Dentures
A crown is a covered service when it is recommended by a 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 reline, 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. Immediate dentures are not subject to the 5-year limitation.

The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6 months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture.

Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the PCD.

Multiple Crown and Bridge Unit Treatment Fee
When a Member's treatment plan includes six (6) or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

Pediatric Specialty Services
If, during a PCD visit, a Member under age eight (8) is unmanageable, the PCD may refer the Member to a Participating Pediatric Specialty Care Dentist for the current treatment plan only. Following completion of the approved pediatric treatment plan, the Member must return to the PCD for further services. If necessary, We must first authorize subsequent referrals to the Participating Specialty Care Dentist. Any services performed by a Pediatric Specialty Care Dentist after the Member's eighth (8th) birthday will not be covered, and the Member will be responsible for the Pediatric Specialty Care Dentist's usual fees.

Second Opinion Consultation (Not applicable in CA):
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 Us, the Member 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 the Member identify a Participating Dentist to perform the second opinion consultation. The Member 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 second opinion consultation shall have the applicable Patient Charge for code D9310.

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

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

Second Opinion Consultation (Applicable in CA only):
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 Us, the Member 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.

Plan will review and approve second opinions if there are questions regarding the following;

- The reasonableness or necessity of a recommended surgical procedure.
- Diagnosis or plan of care, including once care has been initiated.
- Treatment in progress.

Authorization or denial will be provided in an expeditious manner. The Member will be notified in writing if the second opinion is denied and reason for denial will be included. The Member will have the right to file a grievance with the Plan.

A Member Services Representative will help the Member identify a Participating Dentist to perform the second opinion consultation. The Member 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. Authorizations for second opinions are valid for sixty (60) days from the date of approval. Once the second opinion consultation is completed and the Second Opinion Form is returned to the Member Services Representative, you and your dentist will receive a copy of the findings and recommendations.

You may appeal a denial for a second opinion to:

Managed Dental Care (MDC)
Grievance Committee
21255 Burbank Boulevard Suite 120
Woodland Hills, CA 91367

The appeal will be reviewed through the Plan's grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available dental records and the input of the referring dentist. All appeals for the necessity of a second opinion are reviewed by a dentist having appropriate clinical background, as determined by MDC's Dental Director. Second opinions that have not received prior authorization and are for non-covered services are excluded.

MDC has a written policy describing the timeline for second opinions and how we administer the second opinion program. You may request a complete copy of MDC's written policy by contacting the Member Services Department at 800-273-3330, or by mail at P.O. Box 4391, Woodland Hills, CA 91367.

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 (including "gold") is used, the Member will be responsible for the Patient Charge for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

General Anesthesia / IV Sedation
General anesthesia / IV sedation – General anesthesia or IV sedation is limited to services provided by a Participating Oral Surgery Specialty Care Dentist. Not all Participating Oral Surgery Specialty Care Dentists offer these services. The Member is responsible to identify and receive services from a Participating Oral Surgery Specialty Care Dentist willing to provide general anesthesia or IV sedation.

Office Visit Charges
Office visit Patient Charges that are the Member's responsibility after the employer's Group Plan has been in effect for three (3) full years, will be paid to the PCD by Us.

Orthodontic Treatment
The Plan covers orthodontic services as listed under Covered Dental Services and Patient Charges section. Coverage is limited to one course of treatment per Member. We must preauthorize treatment, and treatment must be performed by a Participating Orthodontic Specialty Care Dentist.

The Plan covers, up to, twenty-four (24) months of comprehensive orthodontic treatment. If treatment beyond twenty-four (24) months is necessary, the Member will be responsible for each additional month of treatment, based upon the Participating Orthodontic Specialty Care Dentist's contracted fee.

Except as described under the Treatment in Progress – Orthodontic Treatment and Treatment in Progress – Takeover Benefit for Orthodontic Treatment, 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. 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. (This paragraph is not applicable in MI).

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. (This paragraph is applicable in MI only).

If a Member transfers to another Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member must pay any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. The Member must pay for any additional fixed or removable appliances. The benefit for orthodontic retention is limited to twelve (12) months and covers any and all necessary fixed and removable appliances and 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. (This paragraph is not applicable in MI).

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility. The benefit for orthodontic retention is limited to twelve (12) months and covers any and all necessary fixed and removable appliances and related visits. 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 covered under the Plan. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered. (This paragraph is applicable in MI only).

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

If a Member has orthodontic treatment associated with orthognathic surgery (a Non-Covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member must pay any additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialty Care Dentist's usual fee.

Treatment in Progress (Applicable in CA, CO, FL, NJ, NY and OH only):
A Member may choose to have a Participating Dentist complete an inlay, onlay, crown, fixed bridge, denture, root canal, or orthodontic treatment procedure which: (1) is listed in the Covered Dental Services and Patient Charges Section; and (2) was started but not completed prior to the Member's eligibility to receive benefits under this 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 section.

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

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

- Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment, including retention, at a Patient Charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Treatment in Progress – Takeover Benefit for Orthodontic Treatment (Orthodontic Takeover Treatment-in-Progress) section.

Treatment in Progress (Applicable in IL, IN and MO only):
A Member may choose to have a Participating Dentist complete an inlay, onlay, crown, fixed bridge, denture, root canal, or orthodontic treatment procedure which: (1) is listed in the Covered Dental Services and Patient Charges Section; and (2) was started but not completed prior to the Member's eligibility to receive benefits under this 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 section.

- Restorative Treatment – Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan, may be covered if the Member identifies a Participating Dentist who is willing to complete the procedure at a Patient Charge equal to 85% of the Participating Dentist's usual fee. (There is no additional charge for high noble metal.)

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

- Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Comprehensive orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment, including retention, at a Patient Charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Treatment in Progress – Takeover Benefit for Orthodontic Treatment section.

Treatment in Progress (Applicable in MI only):
A Member may choose to have a Participating General Dentist or Specialty Care Dentist complete an inlay, onlay, crown, fixed bridge, denture, root canal, or orthodontic treatment procedure which: (1) is listed in the Covered Dental Services and Patient Charges Section; and (2) was started by a Non-Participating Dentist but not completed prior to the Member's eligibility to receive benefits under this Plan. We will assist the Member in identifying and transferring to a Participating General Dentist or Specialty Care Dentist willing to complete the procedure at the Patient Charge shown in the Covered Dental Services and Patient Charges section.

This provision includes:

- Restorative Treatment – Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient.
- Endodontic Treatment – Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed.
- Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded.

Treatment-in-Progress – Takeover Benefit for Orthodontic Treatment (Not Applicable in MI):
The Treatment-in-Progress - Takeover Benefit for Orthodontic Treatment (Orthodontic Takeover Treatment-In-Progress) provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another dental HMO plan with the current treating Orthodontist, after this Plan becomes effective.

A Member may be eligible for the Treatment-in-Progress - Takeover Benefit for Orthodontic Treatment only if:

- The Member was covered by another dental HMO plan just prior to the effective date of this Plan and had started comprehensive orthodontic treatment (D8070, D8080, or D8090) with a Participating Network Orthodontist under the prior dental HMO plan;
- The Member has such orthodontic treatment in progress at the time this Plan becomes effective;
- The Member continues such orthodontic treatment with the treating Orthodontist;
- The Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating Orthodontist raised fees due to the termination of the prior dental HMO plan; and
- A Treatment-in-Progress – Takeover Benefit for Orthodontic Treatment Form, completed by the treating Orthodontist, is submitted to Us within 6 months of the effective date of this Plan.

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

The Member will be responsible to have the treating Orthodontist complete a Treatment-in-Progress – Takeover Benefit for Orthodontic Treatment Form and submit it to Us. The Member has 6 months from the effective date of this Plan to have the Form submitted to Us in order to be eligible for the Treatment-in-Progress - Takeover Benefit for Orthodontic Treatment. We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under this Plan is terminated.

This benefit is only available to Members that were covered under the prior dental HMO dental plan and are in comprehensive orthodontic treatment with a Participating Network Orthodontist when this Plan becomes effective with Us. It will not apply if the comprehensive orthodontic treatment was started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another Orthodontist. This benefit applies to Members of new Plans only. It does not apply to Members of existing Plans. And it does not apply to persons who become newly eligible under the Group after the effective date of this Plan.

The benefit is only available to Members in comprehensive orthodontic treatment (D8070, D8080, or D8090). It does not apply to any other orthodontic services. Additionally, we will only cover up to a total 24 months of comprehensive orthodontic treatment.

Continuity of Care Benefit for Orthodontic Treatment in Progress with a Non-Participating Provider (Applicable in MI only):
Continuity of Care Benefit for Orthodontic Treatment with a Non-Participating Provider provides a Member who qualifies, as explained below, a continuity of care benefit.

A Member may qualify for the Continuity of Care Benefit for Orthodontic Treatment in Progress with a Non-Participating Provider only if all of the following conditions are met:

- The Member was covered by another dental HMO plan just prior to the effective date of this Plan;

- The Member had started comprehensive orthodontic treatment (D8070, D8080 or D8090) under the prior plan with an Orthodontist who participated in that plan's network but who does not participate in the Plan network;
- The Member has such orthodontic treatment in progress at the time this Plan becomes effective;
- The Member elects to continue comprehensive orthodontic treatment with the treating Non-Participating Orthodontist;
- The Member's payment responsibility for the such orthodontic treatment has increased because the treating Non-Participating Orthodontist raised fees due to the termination of the prior dental HMO plan; and
- Continuity of Care Benefit for Orthodontic Treatment in Progress with a Non-Participating Provider Form, completed by the treating Non-Participating Orthodontist is submitted to Us within 6 months of the effective date of this Plan.

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

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

This benefit does not apply to any services other than comprehensive orthodontic treatment (D8070, D8080 or D8090). It will not apply if the comprehensive orthodontic treatment was started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another Orthodontist. This benefit applies to Members of new Plans only. It does not apply to Members of existing Plans. And it does not apply to persons who become newly eligible under the Group after the effective date of this plan.

Limitations
NOTE: Time limitations for a service are determined from the date that service was last rendered under this plan.
The codes below in parentheses refer to the CDT Codes as shown in the Covered Dental Services and Patient Charges section.

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

1. Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) – a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
2. Fluoride treatment (D1203, D1204, D1206, D2999) – four (4) in any twelve (12) month period.
3. Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) – limited to one (1) in any two (2) year period on or after the 40th birthday.
4. Full mouth x-rays – one (1) set in any three (3) year period.
5. Bitewing x-rays – two (2) sets in any twelve (12) month period.
6. Panoramic x-rays – one (1) set in any three (3) year period.
7. Sealants – limited to permanent teeth, up to the 16th birthday – one (1) per tooth in any three (3) year period.
8. Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) – a total of one (1) service per quadrant or area in any three (3) year period.
9. Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of one (1) service per area in any three (3) year period.
10. Periodontal scaling and root planing (D4341, D4342) – one (1) service per quadrant or area in any twelve (12) month period.
11. Emergency dental services when more than fifty (50) miles from the PCD's office – limited to a $50.00 reimbursement per incident. (Not applicable in NY and MI).
11. Emergency dental services when more than fifty (50) miles from the PCD's office – limited to a $50.00 reimbursement per incident, after payment of any patient charge which may apply. (Applicable in NY only).
12. Emergency dental services when provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by MDG – limited to the benefit for palliative treatment (code D9110) only. (Not applicable in NY).
12. Emergency dental services when provided by a dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by MDG – limited to fifty percent (50%) of the cost for Emergency Dental Services. (Applicable in NY only).
13. Reline of a complete or partial denture – (one) 1 per denture in any twelve (12) month period.
14. Rebase of a complete or partial denture – (one) 1 per denture in any twelve (12) month period.
15. Second Opinion Consultation – When approved by Us, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan. (Not applicable in CA).

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15. Second Opinion Consultation – When approved by Us, a second opinion consultation will be reimbursed up to fifty dollars ($50.00) per treatment plan. The office visit Patient Charge will apply. (Applicable in CA only).

Exclusions

We won't pay for:

1. Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the Member fails to claim his or her rights to such benefit.
2. Dental services performed in a hospital, surgical center, or related hospital fees.
3. Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered service involving (a) congenitally missing or (b) supernumerary teeth. (Not applicable in FL, MO, NY or NJ).
3. Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered service involving (a) the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child; (b) congenitally missing; or (c) supernumerary teeth. (Applicable in MO only).
4. Any histopathological examination or other laboratory charges.
5. Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
6. Any oral surgery requiring the setting of a fracture or dislocation.
7. Placement of osseous (bone) grafts.
8. Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
9. Any treatment or appliances requested, recommended or performed: (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. (Not applicable in NY).
9. Any treatment or appliances requested, recommended or performed which is solely for cosmetic purposes. Excluded services do not include: (i) reconstructive surgery that is incidental to or follows surgery resulting from trauma, infections or other diseases of the involved part; (ii) reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect; (iii) care or treatment due to accidental injury to sound natural teeth within twelve (12) months of the accident; and (iv) care or treatment necessary due to congenital disease or anomaly. (Applicable in NY only).
10. Precision attachments, stress breakers, magnetic retention or overdenture attachments.
11. The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
12. 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. (Not applicable in NY).
12. Any procedure or treatment method: (a) which does not meet Medically Necessary Services; or (b) which is considered to be experimental in nature. This does not apply if coverage is recommended by a utilization review agent. (Applicable in NY only).
13. Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
14. Replacement or repair of prosthetic appliances damaged due to the neglect of the Member. (Not applicable in FL).
15. Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD, or (b) treatment by a Specialist without a referral by the PCD and approval from Us.
16. Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits.
17. 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; (d) realign teeth.
18. Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ). (Not applicable in NY).
18. Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ), that are incidental to or result from a medical condition. (Applicable in NY only).
19. Dental services, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's assigned PCD, unless We had provided written authorization.
20. Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
21. Treatment which requires the services of a Prosthodontist.
22. Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th birthday.
23. Consultations for non-covered services.
24. Any procedure not specifically listed in the Covered Dental Services and Patient Charges section.
25. 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.
26. Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Restorative Treatment. (Inlays, onlays, crowns or fixed bridges are considered to be (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.) (Not applicable in MI).
26. Inlays, onlays, crowns or fixed bridges or dentures started by a Non-Participating Dentist, but not completed prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress. (Inlays, onlays

crowns or fixed bridges are considered to be: (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be: (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.) (Applicable in MI only).
27. Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.) (Not applicable in MI and NJ).
27. Root canal treatment started by a Non-Participating Dentist, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.) (Applicable in MI only).
27. Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Endodontic Treatment. (Root canal treatment is: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.) (Applicable in NJ only).
28. Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Orthodontic Treatment - Orthodontic Treatment and Treatment in Progress – Takeover Benefit for Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.) (Not applicable in MI and NY).
28. Orthodontic treatment started by a Non-Participating Dentist prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress. (Orthodontic treatment is considered to be started when the teeth are banded.) (Applicable in MI only).
28. Orthodontic treatment started prior to the Member's eligibility to receive benefits under this Plan, except as described under Treatment in Progress – Orthodontic Treatment and Treatment in Progress – Takeover Benefit for Orthodontic Treatment. (Orthodontic treatment is started when the teeth are banded.) (Applicable in NY only).
29. Inlays, onlays, crowns, fixed bridges or dentures started by a Non-Participating Dentist. (Inlays, onlays, crowns, and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the Plan as Emergency Dental Services. (Not applicable in MI and NY).
29. Inlays, onlays, crowns, fixed bridges or dentures started by a Non-Participating Dentist while the Member is covered under this Plan. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which are covered under the Plan as Emergency Dental Services. (Applicable in MI only).
29. Inlays, onlays, crowns, fixed bridges or dentures started by a Non-Participating Dentist. (Inlays, onlays, crowns, and fixed bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the Plan as Emergency Dental Services. (Applicable in NY only).
30. Root canal treatment started by a Non-Participating Dentist. (Root canal treatment is considered to be started when the pulp chamber is opened.) This exclusion will not apply to services that were started and which were covered, under the Plan as Emergency Dental Services. (Not applicable in MI).
30. Root canal treatment started by a Non-Participating Dentist while the Member is covered under this Plan. Root canal treatment is considered to be started when the pulp chamber is opened.) This exclusion will not apply to services that were started and which are covered under the Plan as Emergency Dental Services. (Applicable in MI only).
31. Orthodontic treatment started by a Non-Participating Dentist while the Member is covered under this plan. (Orthodontic treatment is considered to be started when the teeth are banded.)
32. Extractions performed solely to facilitate orthodontic treatment.
33. Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
34. Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
35. Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
36. Procedures performed to facilitate Non-Covered Services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
37. Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
38. 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.
39. Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
40. Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

Current Dental Terminology (c) American Dental Association

Managed DentalGuard - Plan Schedule

Plan U10M5

CDT Codes ++	Covered Dental Services	Patient Charges
D0999	Office visit during regular hours, general dentist only *	$5
	Evaluations	
D0120	Periodic oral examination – established patient	0
D0140	Limited oral evaluation – problem focused	0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	Comprehensive oral evaluation – new or established patient	0
D0170	Re-evaluation – limited, problem focused (established patient, not post-operative visit)	0
D0180	Comprehensive periodontal evaluation – new or established patient	0
	Radiographs/Diagnostic Imaging (Including Interpretation)	
D0210	Intraoral – complete series (including bitewings)	0
D0220	Intraoral – periapical first film	0
D0230	Intraoral – periapical each additional film	0
D0240	Intraoral – occlusal film	0
D0270	Bitewing – single film	0
D0272	Bitewings – two films	0
D0273	Bitewings – three films	0
D0274	Bitewings – four films	0
D0277	Vertical bitewings – 7 to 8 films	0
D0330	Panoramic film	0
	Tests and Examinations	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	50
D0460	Pulp vitality tests	0
D0470	Diagnostic casts	0
	Dental Prophylaxis	
D1110	Prophylaxis – adult, for the first two services in any 12-month period + #	0
D1120	Prophylaxis – child, for the first two services in any 12-month period + #	0
D1999	Prophylaxis – adult or child, for each additional service in same 12-month period + #	60
	Topical Fluoride Treatment (Office Procedure)	
D1203	Topical application of fluoride (prophylaxis not included) – child, for the first two services in any 12-month period + =	0
D1204	Topical application of fluoride (prophylaxis not included) – adult, for the first two services in any 12-month period + =	0
D1206	Topical fluoride varnish; therapeutic application for moderate to high caries risk patients, for the first two services in any 12-month period + =	12
D2999	Topical fluoride (adult or child), each additional service in the same 12-month period + =	20
	Other Preventive Services	
D1310	Nutritional counseling for control of dental disease	0
D1330	Oral hygiene instructions	0
D1351	Sealant – per tooth (molars) ^	14
D9999	Sealant – per tooth (non-molars) ^	35
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer – fixed - unilateral	75
D1515	Space maintainer – fixed - bilateral	110
D1525	Space maintainer – removable - bilateral	110
D1550	Re-cementation of space maintainer	13
D1555	Removal of fixed space maintainer	20
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam – one surface, primary or permanent	28
D2150	Amalgam – two surfaces, primary or permanent	39
D2160	Amalgam – three surfaces, primary or permanent	46
D2161	Amalgam – four or more surfaces, primary or permanent	57
	Resin-Based Composite Restorations - Direct	
D2330	Resin-based composite – one surface, anterior	36
D2331	Resin-based composite – two surfaces, anterior	44
D2332	Resin-based composite – three surfaces, anterior	58
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	66
D2390	Resin-based composite crown, anterior	95
D2391	Resin-based composite – one surface, posterior	56
D2392	Resin-based composite – two surfaces, posterior	75
D2393	Resin-based composite – three surfaces, posterior	90
D2394	Resin-based composite – four or more surfaces, posterior	95
	Inlay/Onlay Restorations ^^	
D2510	Inlay – metallic – one surface **	326
D2520	Inlay – metallic – two surfaces **	368
D2530	Inlay – metallic – three or more surfaces **	383
D2542	Onlay – metallic – two surfaces **	383
D2543	Onlay – metallic – three surfaces **	400
D2544	Onlay – metallic – four or more surfaces **	420
D2610	Inlay – porcelain/ceramic – one surface	326
D2620	Inlay – porcelain/ceramic – two surfaces	368
D2630	Inlay – porcelain/ceramic – three or more surfaces	383
D2642	Onlay – porcelain/ceramic – two surfaces	383
D2643	Onlay – porcelain/ceramic – three surfaces	400
D2644	Onlay – porcelain/ceramic – four or more surfaces	420

CDT Codes ++	Covered Dental Services	Patient Charges
	Crowns – Single Restorations Only ^^	
D2740	Crown – porcelain/ceramic substrate	$450
D2750	Crown – porcelain fused to high noble metal **	430
D2751	Crown – porcelain fused to predominantly base metal	430
D2752	Crown – porcelain fused to noble metal	430
D2780	Crown – ¾ cast high noble metal **	420
D2781	Crown – ¾ cast predominantly base metal	420
D2782	Crown – ¾ cast noble metal	420
D2783	Crown – ¾ porcelain/ceramic	420
D2790	Crown – full cast high noble metal **	430
D2791	Crown – full cast predominantly base metal	430
D2792	Crown – full cast noble metal	430
D2794	Crown – titanium	430
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	18
D2915	Recement cast or prefabricated post and core	18
D2920	Recement crown	18
D2930	Prefabricated stainless steel crown – primary tooth	110
D2931	Prefabricated stainless steel crown – permanent tooth	125
D2932	Prefabricated resin crown	135
D2933	Prefabricated stainless steel crown with resin window	135
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	145
D2940	Sedative filling	30
D2950	Core buildup, including any pins	113
D2951	Pin retention – per tooth, in addition to restoration	24
D2952	Post and core in addition to crown, indirectly fabricated	160
D2953	Each additional indirectly fabricated post – same tooth	50
D2954	Prefabricated post and core in addition to crown	130
D2957	Each additional prefabricated post – same tooth	29
D2960	Labial veneer (resin laminate) – chairside	250
D2970	Temporary crown (fractured tooth)	100
D2971	Additional procedures to construct new crown under existing partial denture framework	125
	Pulp Capping	
D3110	Pulp cap – direct (excluding final restoration)	15
D3120	Pulp cap – indirect (excluding final restoration)	15
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	50
D3221	Pulpal debridement, primary and permanent teeth	50
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	50
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	88
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	90
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures And Follow-up Care)	
D3310	Root canal, anterior (excluding final restoration)	260
D3320	Root canal, bicuspid (excluding final restoration)	300
D3330	Root canal, molar (excluding final restoration)	400
D3331	Treatment of root canal obstruction; non-surgical access	0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	150
D3333	Internal root repair of perforation defects	120
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy – anterior	315
D3347	Retreatment of previous root canal therapy – bicuspid	370
D3348	Retreatment of previous root canal therapy – molar	445
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery – anterior	265
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	300
D3425	Apicoectomy/periradicular surgery – molar (first root)	350
D3426	Apicoectomy/periradicular surgery (each additional root)	110
D3430	Retrograde filling – per root	90
D3950	Canal preparation and fitting of preformed dowel or post	20
	Surgical Services (Including Usual Postoperative Care)	
D4210	Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	188
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	85
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	275
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	165
D4249	Clinical crown lengthening – hard tissue	285
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	410
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	350
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	295
D4271	Free soft tissue graft procedure (including donor site surgery)	298
D4273	Subepithelial connective tissue graft procedures, per tooth	328

CDT Codes ++	Covered Dental Services	Patient Charges
	Non-Surgical Periodontal Service	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$50
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	35
	Other Periodontal Services	
D4910	Periodontal maintenance, for the first two services in any 12-month period + #	32
D4920	Unscheduled dressing change (by someone other than treating dentist)	25
D4999	Periodontal maintenance, each additional service in same 12-month period + #	60
	Complete Dentures (Including Routine Post-Delivery Care)	
D5110	Complete denture – maxillary	580
D5120	Complete denture – mandibular	580
D5130	Immediate denture – maxillary	620
D5140	Immediate denture – mandibular	620
	Partial Dentures (Including Routine Post-Delivery Care)	
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	580
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	580
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	620
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	620
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	675
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	675
	Adjustments to Dentures	
D5410	Adjust complete denture – maxillary	27
D5411	Adjust complete denture – mandibular	27
D5421	Adjust partial denture – maxillary	27
D5422	Adjust partial denture – mandibular	27
	Repairs To Complete Dentures	
D5510	Repair broken complete denture base	69
D5520	Replace missing or broken teeth – complete denture (each tooth)	66
	Repairs To Partial Dentures	
D5610	Repair resin denture base	80
D5620	Repair cast framework	80
D5630	Repair or replace broken clasp	96
D5640	Replace broken teeth – per tooth	62
D5650	Add tooth to existing partial denture	81
D5660	Add clasp to existing partial denture	102
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	223
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	223
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	230
D5711	Rebase complete mandibular denture	230
D5720	Rebase maxillary partial denture	230
D5721	Rebase mandibular partial denture	230
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	130
D5731	Reline complete mandibular denture (chairside)	130
D5740	Reline maxillary partial denture (chairside)	125
D5741	Reline mandibular partial denture (chairside)	125
D5750	Reline complete maxillary denture (laboratory)	186
D5751	Reline complete mandibular denture (laboratory)	186
D5760	Reline maxillary partial denture (laboratory)	186
D5761	Reline mandibular partial denture (laboratory)	186
	Interim Prosthesis	
D5820	Interim partial denture (maxillary)	190
D5821	Interim partial denture (mandibular)	190
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	60
D5851	Tissue conditioning, mandibular	60
	Fixed Partial Denture Pontics ^^	
D6210	Pontic – cast high noble metal **	400
D6211	Pontic – cast predominantly base metal	400
D6212	Pontic – cast noble metal	400
D6214	Pontic – titanium	400
D6240	Pontic – porcelain fused to high noble metal **	400
D6241	Pontic – porcelain fused to predominantly base metal	400
D6242	Pontic – porcelain fused to noble metal	400
D6245	Pontic – porcelain/ceramic	410
	Fixed Partial Denture Retainers – Inlays/Onlays ^^	
D6600	Inlay – porcelain/ceramic – two surfaces	368
D6601	Inlay – porcelain/ceramic – three or more surfaces	383
D6602	Inlay – cast high noble metal, two surfaces **	368
D6603	Inlay – cast high noble metal, three or more surfaces **	383
D6604	Inlay – cast predominantly base metal, two surfaces	368

CDT Codes ++	Covered Dental Services	Patient Charges
	Fixed Partial Denture Retainers – Inlays/Onlays ^^ (continued)	
D6605	Inlay – cast predominantly base metal, three or more surfaces	$383
D6606	Inlay – cast noble metal, two surfaces	368
D6607	Inlay – cast noble metal, three or more surfaces	383
D6608	Onlay – porcelain/ceramic, two surfaces	383
D6609	Onlay – porcelain/ceramic, three or more surfaces	400
D6610	Onlay – cast high noble metal, two surfaces **	383
D6611	Onlay – cast high noble metal, three or more surfaces **	400
D6612	Onlay – cast predominantly base metal, two surfaces	383
D6613	Onlay – cast predominantly base metal, three or more surfaces	400
D6614	Onlay – cast noble metal, two surfaces	383
D6615	Onlay – cast noble metal, three or more surfaces	400
D6624	Inlay – titanium	368
D6634	Onlay – titanium	383
	Fixed Partial Denture Retainers – Crowns ^^	
D6740	Crown – porcelain/ceramic	450
D6750	Crown – porcelain fused to high noble metal **	430
D6751	Crown – porcelain fused to predominantly base metal	430
D6752	Crown – porcelain fused to noble metal	430
D6780	Crown – ¾ cast high noble metal **	430
D6781	Crown – ¾ cast predominantly base metal	430
D6782	Crown – ¾ cast noble metal	430
D6783	Crown – ¾ porcelain/ceramic	430
D6790	Crown – full cast high noble metal **	430
D6791	Crown – full cast predominantly base metal	430
D6792	Crown – full cast noble metal	430
D6794	Crown – titanium	430
	Other Fixed Partial Denture Services	
D6930	Recement fixed partial denture	26
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	160
D6972	Prefabricated post and core in addition to fixed partial denture retainer	130
D6973	Core build up for retainer, including any pins	113
D6976	Each additional cast post – same tooth	50
D6977	Each additional prefabricated post – same tooth	29
D6999	Multiple crown and bridge unit treatment plan – per unit, six or more units per treatment plan ^^	125
	Extractions	
D7111	Extraction, coronal remnants – deciduous tooth	20
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	35
	Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, And Routine Postoperative Care)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	110
D7220	Removal of impacted tooth – soft tissue	145
D7230	Removal of impacted tooth – partially bony	180
D7240	Removal of impacted tooth – completely bony	215
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	240
D7250	Surgical removal of residual tooth roots (cutting procedure)	110
D7261	Primary closure of a sinus perforation	250
	Other Surgical Procedures	
D7280	Surgical access of an unerupted tooth	250
D7283	Placement of device to facilitate eruption of impacted tooth	35
D7285	Biopsy of oral tissue – hard (bone, tooth)	125
D7286	Biopsy of oral tissue – soft	85
D7288	Brush biopsy – transepithelial sample collection	65
	Alveoloplasty – Surgical Preparation Of Ridge For Dentures	
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	53
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	26
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	92
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	65
	Surgical Excision Of Intra-Osseous Lesions	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	200
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	260
	Excision Of Bone Tissue	
D7471	Removal of lateral exostosis (maxilla or mandible)	215
D7472	Removal of torus palatinus	215
D7473	Removal of torus mandibularis	215
	Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue	44
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	48
	Other Repair Procedures	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	100
D7963	Frenuloplasty	168

Managed DentalGuard - Plan Schedule

Plan U10M5

CDT Codes ++	Covered Dental Services	Patient Charges
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$25
D9120	Fixed partial denture sectioning	30
D9215	Local anesthesia	0
D9220	Deep sedation/general anesthesia – first 30 minutes +++	195
D9221	Deep sedation/general anesthesia – each additional 15 minutes +++	75
D9241	Intravenous conscious sedation/analgesia – first 30 minutes +++	195
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes +++	75
	Professional Consultation	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	34
	Professional Visits	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	10
D9440	Office visit – after regularly scheduled hours	50
D9450	Case presentation, detailed and extensive treatment planning	0
	Miscellaneous Services	
D9951	Occlusal adjustment – limited	23
D9971	Odontoplasty – one to two teeth	23
D9972	External bleaching – per arch	165
	Broken appointment	25

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

+ The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first two services in any 12-month period. For each additional service in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan booklet and the Manual (including the Quality Management retrospective review). Other codes may be used to describe Covered Services.

***** The Member will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is an "M". The Plan will be responsible for the Office Visit Fee when the Plan Schedule suffix listed on the ID Card and Eligibility Report is a "G". The ID Card and Eligibility Report will indicate if the Office Visit Fee is $5 or $10.

Routine prophylaxis or periodontal maintenance procedure - a total of four services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a participating periodontal Specialist if done within three to six months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a participating periodontal Specialist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.

= Fluoride Treatment - a total of four services in any 12-month period.

^ Sealants are limited to permanent teeth up to the 16th birthday.

****** If high noble metal is used, there will be an additional Patient Charge for the actual cost of the high noble metal.

^^ The Patient Charge for these services is per unit.

+++ Procedure codes D9220, D9221, D9241 and D9242 are limited to a participating oral surgery Specialist. Additionally, these services are only covered in conjunction with other covered surgical services.

Underwritten by: (IL) - First Commonwealth Insurance Company, (MO) - First Commonwealth of Missouri, (IN) - First Commonwealth Limited Health Services Corporation, (MI) - First Commonwealth Inc., (CA) - Managed Dental Care, (TX) - Managed DentalGuard, Inc. (DHMO), (NJ) - Managed DentalGuard, Inc., (FL, NY) - The Guardian Life Insurance Company of America. All First Commonwealth, Managed DentalGuard, Inc., and Managed Dental Care entities referenced are wholly-owned subsidiaries of The Guardian Life Insurance Company of America. Limitations and exclusions apply. Plan documents are the final arbiter of coverage.

The Guardian Life Insurance Company of America, New York, NY 2008-6567

MANAGED DENTALGUARD ORTHODONTIC BENEFITS

Managed DentalGuard Orthodontic Plan Schedule – Option W

CDT Codes	Covered Services and Patient Charges	Patient Charges	Orthodontics In Progress
	Orthodontics		
D8070	Comprehensive orthodontic treatment of the transitional dentition **		
D8080	Comprehensive orthodontic treatment of the adolescent dentition **	Child: $1500	***
D8090	Comprehensive orthodontic treatment of the adult dentition **	Adult: 2800	***
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	250	***
D8670	Periodic orthodontic treatment visit	0	***
D8680	Orthodontic retention	400	***
	Broken appointment	25	***

Current Dental Terminology (CDT) © American Dental Association (ADA) v.08192

** Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above and employee or spouse. A Member's age is determined on the date of banding.

*** Treatment in progress: Orthodontic Treatment – Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are listed on the Plan Schedule and were started but not completed prior to the Member's eligibility to receive benefits under this plan may be covered if the Member identifies a Participating Orthodontic Specialty Care Dentist who is willing to complete the treatment at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. In this situation retention services would also be at 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. 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. Also refer to the Orthodontic Takeover Treatment-in-Progress section.

++ Covered Services are subject to exclusions, limitations and Plan provisions as described in Member's Plan Booklet and the Manual.

The Plan Covers:

- Orthodontic services as listed under Covered Dental Services and Patient Charges, limited to one (1) course of treatment per Member. We must preauthorize treatment, and it must be performed by a Participating Orthodontic Specialist Dentist.
- Up to twenty-four (24) months of comprehensive orthodontic treatment.
- Treatment plan and records, including initial records and any interim and final records.
- Comprehensive orthodontic treatment, including the fixed banding appliances and related visits only.
- Retention services following a course of comprehensive orthodontic treatment that was covered under this Plan.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Plan provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialist Dentist's usual fee.

This Plan Does Not Cover:

- Any procedure listed as an exclusion, in excess of Plan limitations, or as not covered under MDG.
- Orthodontic treatment performed by any dentist other than a Participating Orthodontic Specialist Dentist.
- Limited orthodontic treatment and interceptive (Phase I) treatment.
- Treatment beyond twenty-four (24) months. (The Member will be responsible for an additional charge for each additional month of treatment, based upon the Participating Orthodontic Specialist Dentist's contracted fee.)
- Except as described under treatment in progress – orthodontic treatment, 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 Orthodontist Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment.
- Orthodontic services after a Member's coverage terminates.
- Any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or linqual brackets.
- Procedures, appliances or devices to (a) guide minor tooth movement or (b) to correct or control harmful habits.
- 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.
- Extractions performed solely to facilitate orthodontic treatment.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- If a Member transfers to another Participating Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this Plan, the Member will be responsible for any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

Dental Maximum Rollover®

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). If you reach your Plan Annual Maximum in future years, you can use money from your MRA. To qualify for an MRA, you must have a paid claim (not just a visit) and must not have exceeded the paid claims threshold during the benefit year. Your MRA may not exceed the MRA limit. You can view your annual MRA statement detailing your account and those of your dependents on www.GuardianAnytime.com.

Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$1000	$500	$250	$350	$1000
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $2,000 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

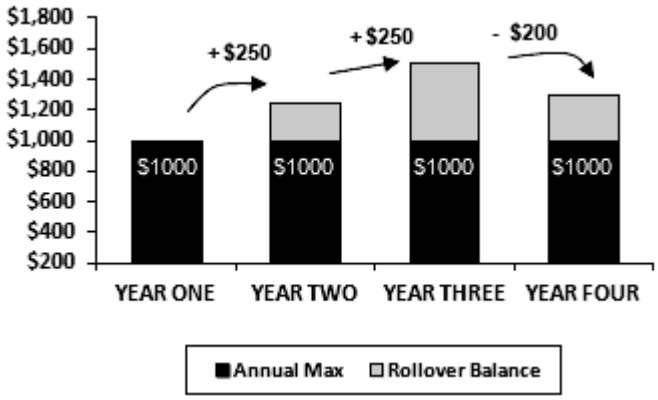
Here's how the benefits work:

YEAR ONE: Jane starts with a $1,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $500 Threshold, she receives a $250 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $1,250. This year, she submits $50 in claims and receives an additional $250 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $1,500. This year, she submits $1,200 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $1,300 ($1,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

NOTES:

You and your insured dependents maintain separate MRAs based on your own claim activity. Each MRA may not exceed the MRA limit.

Cases on either a calendar year or policy year accumulation basis qualify for the Maximum Rollover feature. For calendar year cases with an effective date in October, November or December, the Maximum Rollover feature starts as of the first full benefit year. For example, if a plan starts in November of 2013, the claim activity in 2014 will be used and applied to MRAs for use in 2015.

Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America or its subsidiaries, New York, NY. Products are not available in all states. Policy limitations and exclusions apply.

Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage.

Policy Form #GP-1-DG2000, et al.

Dental Maximum Rollover®

Save Your Unused Claims Dollars For When You Need Them Most

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Please note that actual maximum limitations and thresholds vary by plan. Your plan may vary from the one used below as an example to illustrate how the Maximum Rollover functions.

Plan Annual Maximum*	Threshold	Maximum Rollover Amount	In-Network Only Rollover Amount	Maximum Rollover Account Limit
$2000	$800	$400	$600	$1500
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Additional dollars added to Plan Annual Maximum for future years if only in-network providers were used during the benefit year	Plan Annual Maximum plus Maximum Rollover cannot exceed $3,500 in total

* If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan.

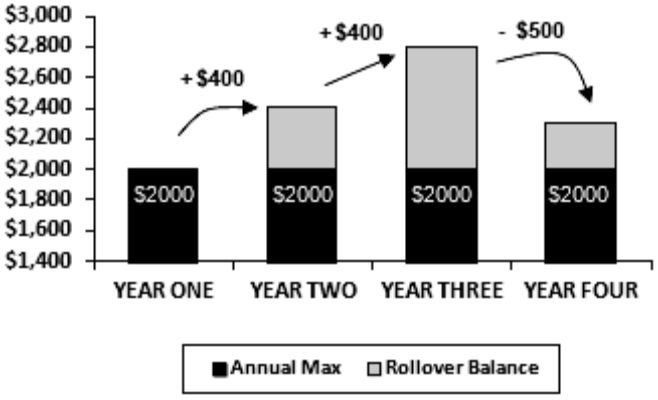
Here's how the benefits work:

YEAR ONE: Jane starts with a $2000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $800 Threshold, she receives a $400 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $2,400. This year, she submits $50 in claims and receives an additional $400 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $2,800. This year, she submits $2,500 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $2,300 ($2,000 Plan Annual Maximum + $300 remaining in her Maximum Rollover Account).



For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

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Under either benefit year set up (calendar year or policy year), Maximum Rollover for new entrants joining with 3 months or less remaining in the benefit year, will not begin until the start of the next full benefit year. Maximum Rollover is deferred for members who have coverage of Major services deferred. For these members, Maximum Rollover starts when coverage of Major services starts, or the start of the next benefit year if 3 months or less remain until the next benefit year. (Actual eligibility timeframe may vary. See your Plan Details for the most accurate information.)

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Policy Form #GP-1-DG2000, et al.

Preventive Advantage – *Additional Details*

Enjoy preventive dental care, with no deduction from your plan's annual maximum.

With Preventive Advantage, you can receive all preventive care, including exams, cleanings, x-rays and fluoride treatments, without having the benefit expenses deducted from your annual maximum. That means you can stretch your benefit even further for even more savings to you.

- **Simply pay the applicable co-insurance and deductible for Preventive care (if any)**
- **The entire annual maximum amount is preserved for other dental needs**
- **Preventive care will continue to be covered even after the annual maximum is met**

Dentists recommend oral exams and cleanings every six months. Now you can take good care of your oral health without having to balance the need for dental procedures.

Take advantage of Preventive Care for good oral health	…and save the annual maximum for other dental care needs, such as:
▪ Oral exams ▪ Cleaning ▪ X-Rays ▪ Fluoride treatments	▪ Fillings ▪ Root canal ▪ Crowns ▪ Oral surgery ▪ Dentures and bridgework

Here's how this benefit works for you:

Joe visits the dentist for his annual cleaning. His deductible is $25. The cleaning costs $125. All expenses above the deductible are covered and, with the Preventive Advantage plan option, will not reduce the Annual Maximum.

For Overview of your Dental Benefits, please see About Your Benefit Section of this Enrollment Booklet.

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Guardian®

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: 05/01/2016

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

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

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

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

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

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.
- 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.

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

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

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

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

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

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

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

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Accounting 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.

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

The Guardian Life Insurance Company of America
The Guardian Life Insurance Company Of America underwrites dental coverage.

Managed DentalGuard, Inc., a subsidiary of The Guardian Life Insurance Company of America
Managed DentalGuard, Inc., underwrites group pre-paid dental coverages.

Enrollment/Change Form

Guardian Life, P.O. Box 14319,
Lexington, KY 40512

Please print clearly and mark carefully.

Employer Name: **THE UNITED METHODIST CHURCH OF GREATER NEW JERSEY**

Group Plan Number: **00527280**

Benefits Effective:_____

PLEASE CHECK APPROPRIATE BOX Initial Enrollment Re-Enrollment Add Employee/Dependents Drop/Refuse Coverage Information Change Increase Amount Family Status Change

Class:_____ Division:_____ Subtotal Code:_____ **(Please obtain this from your Employer)**

About You:
First, MI, Last Name:

Social Security Number
___ ___ ___ - ___ ___ - ___ ___ ___ ___

Address	City	State	Zip

Gender: M F Date of Birth (mm-dd-yy): ____ - ____ - ____ Phone: ( ) -

Email Address:

Are you married or do you have a spouse? Yes No Date of marriage/union:____-____-_____
Do you have children or other dependents? Yes No Placement date of adopted child: ____-____-_____

About Your Job: Hours worked per week: _____ Job Title:

Work Status:
Active Retired Cobra/State Continuation

Date of full time hire: _____ - _____ - _____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

		Gender	Social Security Number	
Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		M F	_____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	
Child/Dependent 1: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 2: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

DATE FORM PUBLISHED: Jan 22, 2019

Child/Dependent 3: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent
Child/Dependent 4: Address/City/State/Zip: Phone: ( ) -	Add Drop	Gender M F	Social Security Number _____ - _____ - _____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____	Status (check all that apply) Student (post high school) Disabled Non standard dependent

Drop Coverage:

Drop Employee Drop Dependents

The date of withdrawal cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

Termination of Employment Retirement

Last Day Worked: _____-_____-_____

Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Dropped:

Dental Employee Spouse Child(ren)

Loss Of Other Coverage:

I and/or my dependents were previously covered under another insurance plan. Loss of coverage was due to:

Termination of Employment: _____-_____-_____

Divorce _____-_____-_____

Death of Spouse _____-_____-_____

Termination/Expiration of Coverage _____-_____-_____

Coverage Lost Dental

I have been offered the above coverage(s) and wish to drop enrollment for the following reasons:

Covered under another insurance plan

Other _____

(additional information may be required)

Dental Coverage: **You must be enrolled to cover your dependents. Check only one box.**

Your premium	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: Managed Dental Care	$41.01	$81.99	$112.53	$145.11
Option 2: Buy Up	$121.02	$245.70	$275.85	$424.32
Option 3: Base	$86.43	$175.68	$198.03	$304.17

- **If Managed Dental Care is elected, you must have a Primary Care Dentist (PCD). Please designate your PCD(s) by listing dental office location number(s) for each person. Please visit guardianlife.com for a list of providers. If you do not select a PCD, one will be assigned for you.**

Employee _____ Spouse _____ Child(ren) _____

I do not want this coverage. If you do not want this Dental Coverage, please mark all that apply:

I am covered under another Dental plan

My spouse is covered under another Dental plan

My dependents are covered under another Dental plan

Signature

I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.

I understand that the premium amounts shown above are estimations and are for illustrative purposes only.

Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.

If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.

Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.

I hereby apply for the group benefit(s) that I have chosen above.

Guardian Group Plan Number: **00527280** Please print employee name:

I understand that I must meet eligibility requirements for all coverages that I have chosen above.

I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.

I acknowledge and consent to receiving electronic copies of Guardian applicable coverage related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.

I attest that the information provided above is true and correct to the best of my knowledge.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: (if you are not a resident of New York this statement does not apply to you): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

The requested activity is believed eligible and is approved by the Employer.

SIGNATURE OF EMPLOYER REPRESENTATIVE X _____ **DATE** _____

REPRESENTATIVE'S TITLE: _____

Enrollment Kit 00527280, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form. These statements apply only to residents of the noted States:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER

Maryland : Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

INSTRUCTIONS

Employers - You must complete the Policyholder and Signature sections in order for this application to be processed.

Employees - You must complete all sections that apply to you and your dependents including the Signature section in order for this application to be processed.

- Please PRINT except when a signature is requested.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, select Disabled in Section E, and attach proof of disability.
- If a dependent is a full-time post-secondary student, you must attach a current course schedule or a letter from the school or its authorized representative confirming full-time student status.

CONDITIONS OF ENROLLMENT - EMPLOYEE ACKNOWLEDGEMENTS AND AGREEMENTS

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer reporting agency, and any employer to give Guardian, or any consumer reporting agency acting on behalf of Guardian, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Guardian has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Guardian will provide coverage in accordance with the terms of the contract for the group plan.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group plan if premiums are not paid timely. I authorize my Employer to withhold payments from my wages as contribution to the premium, as appropriate.

DETACH ENTIRE FORM AND RETURN TO YOUR EMPLOYER