GUARDIAN®

Group Number: 00459930

CITY OF COPPELL

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.

PLAN HIGHLIGHTS

- Dental

Dental Benefit Summary

Group Number: 00459930

About Your Benefits:

A visit to your dentist can help you keep a great smile and prevent many health issues. But dental care can be costly and you can be faced with unforeseen expenses. Did you know, a crown can cost as much as $1,400[1]? Guardian dental insurance will help you pay for it. With access to one of the largest network of dental providers in the country, who agreed to charge negotiated fees for their services of up to 30% less than average charges in the same community, you will benefit from lower out-of-pocket costs, quality care from screened and reviewed dentist, no claim forms to file, and excellent customer service. Enroll today and smile next time you see your dentist!

[1]http://health.costhelper.com/dental-crown.html.

Option 1: With your **DHMO** 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: With your **PPO** 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: DHMO**	**Option 2: PPO**	
Your Network is	Managed DentalGuard	DentalGuard Preferred	
Plan year deductible		*In-Network*	*Out-of-Network*
Individual	No deductible	$50	$50
Family limit		3 per family	
Waived for		Preventive	Preventive
Charges covered for you (co-insurance)	*Network only*	*In-Network*	*Out-of-Network*
Preventive Care	You pay a copay for each	100%	100%
Basic Care	covered procedure. See	80%	80%
Major Care	"Plan Details", for	50%	50%
Orthodontia	more information.	50%	50%
Annual Maximum Benefit	Unlimited	$5000	$5000
Maximum Rollover	Maximum Rollover is not	Yes	
Rollover Threshold	applicable for this plan type.	$1000	
Rollover Amount		$500	
Rollover Account Limit		$1500	
Lifetime Orthodontia Maximum	Not Applicable	$1000	
Office visit copay	$0	None	
Dependent Age Limits	26	26	

A Sample of Services Covered by Your Plan:

		Option 1: DHMO *You Pay*	Option 2: PPO *Plan pays (on average)*	
		Network only	*In-network*	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	$0	100%	100%
	Frequency:	2 times in 12 months^	Once Every 6 Months	
	Fluoride Treatments	$0	100%	100%
	Limits:	No Age Limits	Under Age 14	
	Oral Exams	$0	100%	100%
	Sealants (per tooth)	$0	100%	100%
	X-rays	$0	100%	100%
Basic Care	Anesthesia*	Restrictions Apply	80%	80%
	Fillings‡	$0	80%	80%
	Perio Surgery	$200-380	80%	80%
	Periodontal Maintenance	$0	80%	80%
	Frequency:	2 times in 12 months^ (Standard)	Once Every 6 Months (Standard)	
	Repair & Maintenance of Crowns, Bridges & Dentures	$0-160	80%	80%
	Root Canal	$120-270	80%	80%
	Scaling & Root Planing (per quadrant)	$0	80%	80%
	Simple Extractions	$0	80%	80%
	Surgical Extractions	$30-200	80%	80%
Major Care	Bridges and Dentures	$381-575	50%	50%
	Inlays, Onlays, Veneers**	$250-370	50%	50%
	Single Crowns	$375	50%	50%
Orthodontia	Orthodontia	$2,500-2,800	50%	50%
	Limits:	Adults & Child(ren)	Adults & Child(ren)	
Cosmetic Care	Bleaching	$165	Not Covered	Not Covered

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 plan 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. The total number of cleanings and periodontal maintenance procedures are combined in a 12 month period. *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 handout is for illustrative purposes only and is an approximation. If any discrepancies between this handout and your paycheck stub exist, your paycheck stub prevails.

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date..

Find A Dentist:

Visit www.GuardianAnytime.com
Click on "Find A Provider"; You will need to know your plan and dental network, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

- Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred 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.
- ImImportant information about Guardian's Managed DentalGuard Pre-Paid (Florida, New York) Plan, Guardian's Managed DentalGuard (Colorado) Plan , Managed DentalGuard Inc.'s (Ohio) Plan, Managed Dental Care's DHMO (California) Plan, Managed DentalGuard, Inc.'s Managed DentalGuard (New Jersey) Plan, Managed DentalGuard, Inc.'s Managed DentalGuard DHMO (Texas) Plan and Managed DentalGuard -LIBERTY Dental Plan of Nevada, Inc. (Nevada): This plan provides pre-paid dental benefits through a network of participating general dentists and specialty care dentists. All covered services must be provided by the member's Primary Care Dentist. Specialty care services are covered only when referred by the member's Primary Care Dentist and approved in advance by Managed DentalGuard. Only those services listed in the plan are covered. Certain services are subject to annual or other periodic limitations. Where orthodontic benefits are specifically included, the plan provides for one course of comprehensive treatment per lifetime, per member. Unless specifically included, the Managed DentalGuard plan does not provide orthodontic benefits if comprehensive orthodontic treatment or retention is in progress as of the member's effective date under the Managed DentalGuard plan. The services, exclusions and limitations listed here do not constitute a contract and are a summary only. The Managed DentalGuard plan documents are the final arbiter of coverage. GP-1-MDG1, et al. or GP-1-MDG-FL-1-08, et al. (Florida), GP-1-MDG-NY1, et al. or GP-1-MDG-NY-1-08, et al. (New York), GP-1-MDG-CO-1, et al. (Colorado), GP-1MDC1, et al. or GP-1-MDC-CA-1-08, et al. (California), GP-1-MDG-1-NJ, et al. or GP-1-MDG-NJ-1-08, et al. (New Jersey), GP-1-MDG-TX1, et al. or GP-1-MDG-TX-1-08, et al. (Texas), GP-1-MDG-OH-1, et al. (Ohio), NV110717, et al (Nevada).
- **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

MANAGED DENTALGUARD ORTHODONTIC BENEFITS

Managed DentalGuard Orthodontic Plan Schedule – Option V

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: $2500	***
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.

MANAGED DENTALGUARD - TEXAS

FINE PRINT

(For MDG Plans (U10, U11, U20, U21, U30, U31, U40, U41, U50, U51, U60, and U61)

This is only a summary of benefits and the enrollee must refer to his/her Evidence of Coverage for complete terms and conditions of coverage.

Managed DentalGuard (MDG) combines broad dental coverage with a number of cost-saving dental 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 premiums.

Emergency Dental Services

The MDG network 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 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 MDG for authorization to obtain services from another Dentist. If the Member is unable to obtain a referral or authorization for Emergency Dental Services, the Member may seek Emergency Dental Services from any Dentist. Then the Member must submit to MDG: (a) the bill incurred as a result of the emergency; (b) evidence of payment; and (c) a brief explanation of the emergency. This should be done within 60 days or as soon as reasonably possible. MDG will reimburse the Member for the cost of 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 MDG, coverage is limited to the benefit for palliative treatment (code D9110) 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.

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, 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 is 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 Specialty Care Dentist.

Crowns, Bridges and Dentures

A crown is a covered service when it is recommended by the PCD. The replacement of a crown 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/Bridge Unit Treatment Fee

When a Member's treatment plan includes 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 Charge section.

Pediatric Specialty Services

If during a PCD visit, a Member under age 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 referral to the Participating Specialty Care Dentist. Any services performed by the Pediatric Specialty Care Dentist after the Member's 8th birthday will not be covered, and the Member will be responsible for the Pediatric Specialty Care Dentist's usual fee.

Second Opinion Consultation

A Member may wish to consult another Dentist for a second opinion regarding services recommended or performed by: (a) his or her PCD; or (b) a Participating Specialty Care Dentist through an authorized referral. To have a second opinion consultation covered by MDG, 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 MDG. 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 MDG.

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 dentist's fee over $50.00.

Noble and High Noble Metals

The Plan provides for the use of noble metals for inlays, onlays, crowns, and fixed bridges. When high noble metal (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. The Member's Patient Charge shown in the Covered Dental Services Patient Charge section.

Office Visit Charges

Office visit Patient Charges that are the Member's responsibility after the Employer's group has been in effect for three 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 24 months of comprehensive orthodontic treatment. If treatment beyond 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 Plan Schedule's section only following a course of comprehensive orthodontic treatment started and completed under this Plan.

If a Member transfers to another 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.

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

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

If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the 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.

Treatment in Progress

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 listed on 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 the Patient Charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover Treatment-in-Progress section.

Treatment-In-Progress – Takeover Benefit for Orthodontic Treatment

The Treatment-In-Progress – Takeover Benefit for Orthodontic Treatment 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.

Limitations On Benefits For Specific Covered Services

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) or periodontal maintenance procedures, which are not medically necessary – a total of 4 services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within 3 to 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. 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 once in a 2-year period (or any 12-month period, if the Plan has been in effect for less than one year) on or after the 40th birthday.
- 3. Full mouth x-rays – 1 set in any 3-year period (or any 2-year period if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year, unless diagnostically necessary.
- 4. Bitewing x-rays – 2 sets in any 12-month period.
- 5. Panoramic x-rays – 1 film in any 3-year period, (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year), unless diagnostically necessary.
- 6. Sealants – Up to the 16th birthday, 1 per tooth in any 3-year period, (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- 7. Gingival flap procedures (D4240, D4241) – Once per quadrant or area in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- 8. Osseous surgery procedures (D4260, D4261) – Once per quadrant or area in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year.
- 9. Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) – a total of 1 service per area in any 3-year period (or any 2-year period, if the Plan has been in effect for one year or more but less than 2 years; or any 12-month period, if the Plan has been in effect for less than one year).
- 10. Periodontal scaling and root planing (D4341, D4342) – 1 service per quadrant or area in any 12-month period.
- 11. Emergency dental services when more than 50 miles from the PCD's office – limited to a $50.00 reimbursement per incident.
- 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.
- 13. Reline of a complete or partial denture – 1 per denture in any 12-month period.
- 14. Rebase of a complete or partial denture – 1 per denture in any 12-month period.
- 15. Second Opinion Consultation – when approved by us, a second opinion consultation will be reimbursed up to $50.00 per treatment plan.
- **Exclusions**
- Any condition for which benefits of any nature are recovered whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any histopathological examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.

- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any 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.
- Precision attachments, stress breakers, magnetic retention or overdenture attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
- Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD; or (b) treatment by a specialist without a referral from the PCD and approval from us. This exclusion will not apply to Emergency Dental Services.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely: (a) to alter vertical dimension; (b) to replace tooth structure lost due to attrition or abrasion; (c) to splint or stabilize teeth for periodontal reasons; or (d) except as described in the Orthodontic Treatment section, to realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- 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.
- Cephalometric x-rays except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a Prosthodontist.
- Treatment which requires the services of a Pediatric Specialty Care Dentist, after the Member's 8th [eighth] birthday.
- Consultations for non-covered services.
- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.
- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges 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.)
- 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.)
- 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 considered to be started when the teeth are banded.)
- 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.

- 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.
- 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.)
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
- 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.
- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

Specialty Care Referral Process

Your Primary Care Dentist is responsible for performing or coordinating all of your dental services. If you need services that your Primary Care Dentist is unable to perform, he or she will, with approval from MDG, refer you to a Participating Specialty Care Dentist for the service(s) you need.

The MDG network includes dentists specializing in oral surgery, periodontics, endodontics, orthodontics, and pediatric dentistry, located in your service area. If there is no Participating Specialty Care Dentist in your service area, the Member Services Department will refer you to a Non-Participating Specialty Care Dentist of MDG's choice. MDG will not cover dental care provided to you by a Specialty Care Dentist not pre-authorized by MDG to provide that care.

Any authorized specialty care services are subject to all of the same terms, conditions, limitations and exclusions that apply to services performed by your Primary Care Dentist, and you must pay the applicable Patient Charges. Remember: you must get specialty care services referred by your Primary Care Dentist and authorized by MDG. If you do not have an authorized referral, you will be responsible for all of the costs associated with your care.

The only exception to this rule is for Emergency Dental Services, which are covered as described above.

Continuity of Care

If your Primary Care Dentist terminates his or her participation in the network, MDG will notify you of the termination in writing, as soon as possible. You will have the opportunity to choose another Participating Dentist. If you have a dental service in progress at the time of your original Dentist's termination we will either arrange for completion of the services by your original Dentist or make arrangements for another Participating Dentist to complete the service. If you have "special circumstances" as defined in the Texas Insurance Code, you may be eligible for up to 90 days of continuing treatment from your Participating Dentist after his or her termination.

Complaint And Appeals Process

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

The Member or Dentist may contact the Member Services Department to review a concern or file a complaint. The Quality of Care Liaison (QCL) may be contacted to file a complaint involving an adverse determination (utilization review), to file an appeal of an adverse determination, or to request a review by an independent review organization (IRO).

"Complaint" means any dissatisfaction expressed by a Member, the Member's designated representative or the Member's Dentist, by telephone or in writing, regarding the Plan's operation, including, but not limited to plan administration; procedures related to a review or appeal of an adverse determination; denial of access to a referral; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service was provided; and disenrollment

decisions. This term does not include: (a) a misunderstanding or a problem of misinformation that is resolved promptly by clearing up the misunderstanding or supplying the appropriate information to the satisfaction of the Member; or (b) a Dentist's or Member's oral or written expression of dissatisfaction or disagreement with an adverse determination.

"Adverse Determination" means a determination by Us or a utilization review agent that a proposed or delivered dental service, by specialty care referral, which would otherwise be covered under the Member's Plan, is or was not a medically necessary service and may result in non-coverage of the dental procedure.

"Medically necessary services", as related to covered services, means those services, requested by specialty care referral, which are: (1) adequate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (2) consistent with nationally accepted standards of practice.

"Utilization review agent" means an entity that conducts utilization review for Us.

"Utilization review" means a system for prospective or concurrent review of the medical necessity and appropriateness of dental services being provided or proposed to be provided to a Member. The term does not include a review in response to an elective request for clarification of coverage.

Member Services and the QCL can be contacted by telephone at:

1-888-618-2016

Or by mail at:

P.O. Box 4391, Woodland Hills, CA 91367

The Plan hours are from 8:30 a.m. to 6:30 p.m. Central Time. A Member may leave a message when calling after business hours, weekends, or holidays. At the time the Member is notified of an Adverse Determination, the forms required to file an appeal for an Independent Review are included with the notification letter. The Member has a right to request an Independent Review anytime after the first appeal to MDG. If the Member wishes to contact the Texas Department of Insurance to discuss the Independent Review process, the telephone number is:

1-888-834-2476

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

Member Service Representatives document each telephone call and work with the Member to resolve their oral Complaint. The Member will be sent, within 5 days from the date of receipt of the telephone call, an acknowledgement letter and a Complaint Form to complete if the Member desires additional review.

Upon receipt of a written Complaint or the Complaint Form, the QCL or QCL designee sends an acknowledgment letter to the Member within 5 business days. If a Complaint is made orally, an acknowledgment letter accompanied by a one-page complaint form that prominently and clearly states that the form must be returned to MDG for prompt resolution of the Complaint.

MDG will review and resolve the written Complaint within 30 calendar days after the date of receipt.

The QCL or QCL designee is responsible for obtaining the necessary documentation; building a case file; and researching remaining aspects of the Complaint and any additional information. MDG may arrange a second opinion, if appropriate. Upon receipt of complete documentation, a resolution is determined by the QCL or QCL designee. Any issue involving a matter of quality of care will be reviewed by the Dental Director or the Director's designee and, if needed, with the Vice President of Network Management, legal counsel, and/or the Complaint Committee and/or the Peer Review Committee.

The QCL or QCL designee is responsible for writing a resolution letter to the Member indicating the outcome of the review and the specialization of the dentists consulted, if applicable. Treatment plans and procedures; general dentist and/or specialty care dentist clinical findings and recommendations; plan guidelines; benefit information; and contractual reasons for the resolution will be described, as appropriate. A copy of the Plan's appeal process will be enclosed with each resolution letter in the event the Member elects to have his or her Complaint re-evaluated. In addition, the method by which a Member can contact the Texas Department of Insurance for additional assistance will be noted in the resolution letter.

Complaints regarding an Adverse Determination will be handled according to the established process outlined in the Appeal of Adverse Determination section (below).

The Texas Department of Insurance may review Complaint documentation during any Plan review.

MDG asserts it is prohibited from retaliating against a group Planholder or a Member because the group Planholder or Member has filed a Complaint against the Plan or appealed a decision of the Plan. The Plan is prohibited from retaliating against a dentist or network provider because the Dentist or network provider has, on behalf of a Member, reasonably filed a Complaint against the Plan or appealed a decision of the Plan.

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

Complaint Committee and the Peer Review Committee: At the discretion of the Dental Director or the Director's designee and/or the QCL or QCL designee, Complaints may be referred to the Complaint Committee or the Peer Review Committee for review and resolution.

The role of the Committees is to review Complaints, on a case by case basis, when the nature of the Complaint requires Committee participation and decision to reach resolution.

Once the matter has been resolved, the QCL or QCL designee will respond to the Member and will indicate in the file and the Quality Management Program (QMP) database that the matter is closed.

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

Minutes will be compiled for each Committee Meeting and will be maintained in the office of MDG. Minutes of the meetings will be forwarded to the Quality Improvement Committee and the Board of Directors.

Complaint Appeal Process: If the Member is not satisfied with the resolution, the Member may make a telephone or written request that an additional review be conducted by a "Complaint Appeal Committee." The telephone appeal request will be logged in the Member's file and the Member will be asked to send the request in writing. An acknowledgment letter will be forwarded to the Member within 5 business days from receipt of the written request.

This Committee will meet within 30 days of the date the written appeal is received. The Committee is composed of an equal number of:

Representative(s) from MDG;

Representative(s) selected from Participating General Dentists;

Representative(s) selected from Participating Specialty Care Dentists (if the Complaint concerns specialty care); and

Representative(s) selected from Plan Members who are not MDG employees.

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

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

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

The Committee will meet within the Member's county of residence or the county where the Member normally receives dental care or at another site is agreed to by the Member, or address a written appeal to the complaint appeal board.

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

Not less than 5 working days prior to the Committee meeting unless the Complainant agrees otherwise, the Plan will submit to the Member any and all documentation to be presented to the Committee, and the specialization of any dentist consulted during the investigation.

The Member will receive a written notice of resolution within 30 days from the date of receipt of the written request for appeal. The resolution notice will include a written statement of the specific medical determination, clinical basis and the contractual criteria used to reach the final decision. The notice shall also prominently and clearly state the toll free telephone number and address of the Texas Department of Insurance.

MDG will pay for the expenses of the Complaint Appeal Committee representative(s) from MDG and representative(s) selected from Participating General Dentists and/or Participating Specialty Care Dentists and the expenses of representative(s) selected from Plan Members.

Following the decision of the Committee, the Member and MDG each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Participating Dentist.

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

P. O. Box 149104
Austin, TX 78714-9104
Telephone: 1-800-252-3439
Fax #: 1-512-475-1771
Web: httb://www.tdi/state.tx.us
E-Mail: ConsumerProtection@tdi.state.tx.us

Minutes will be compiled for each Committee Meeting and will be maintained in the office of MDG. Minutes of the meetings will be forwarded to the Quality Improvement Committee and the Board of Directors.

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

If the appeal of the emergency Complaint involves an Adverse Determination and involves a life-threatening condition, the Member or Member's designee and Dentist may request the immediate assignment of an IRO without filing an appeal. (See the Appeal of Adverse Determination section below.)

Documentation/Database: With MDG's QMP database, it will be possible to track a Member's concern from the initial call through the final resolution of the issue. All steps in the resolution process may be documented in the database. Information will be accessible on groups, Members, and Dentists. The database will be accessed for information for the Quality Improvement Committee, the Complaint Committee and the Credentialing Committee. The database will provide aging reports and the reasons that Complaints are not resolved within 30 days, if applicable.

"Reason Codes" will be used in the database for tracking purposes. Reason Codes categories are Access, Benefits and Coverage, Claims, and Quality of Care.

The objectives of the logging system in the database are:

1. Accurate tracking of status of Complaints;
2. Accountability of the different departments/personnel involved in the resolution process; and
3. Trending of the dental providers, Members and groups for appropriate follow-up.

Documentation/Files: Each written Complaint will be logged into the database by the QCL or QCL designee on the date it was received. The Member's data management system is documented that a Complaint has been received and is being reviewed by the QCL or QCL designee. A paper file is created and labeled with the Member's name and social security number. Any subsequent follow-up information is recorded in the file by the QCL or QCL designee. The file is to be kept in the Complaint File for 3 years. The file will include all correspondence regarding the issue, copies of records, radiographs and resolution. Only when a resolution is completed can the Complaint be closed and noted as closed in the Member's file and the database. Complaint files are available for regulatory review.

The Complaint Log will be reviewed quarterly by the Quality Improvement Committee.

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

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

(1) We shall provide to the Member, the Member's designated representative or the Member's Dentist information on how to appeal the denial of an adverse determination to an independent review organization;

(2) Such information must be provided by Us to the Member, the Member's designated representative or the Member's Dentist at the time of the denial of the appeal;

(3) We shall provide to the Member, the Member's designated representative or the Member's Dentist the prescribed form;

(4) The form must be completed by the Member, the Member's designated representative or the Member's Dentist and returned to Us to begin the independent review process;

(5) In life threatening situations, the Member, the Member's designated representative or Member's Dentist may contact Us by telephone to request the review and provide the required information.

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

Non-Retaliation

MDG will not engage in retaliatory action against a Member because that Member has filed a complaint against MDG, or has appealed a decision of MDG. MDG will not engage in retaliatory action against a Participating Dentist because that Dentist has, on behalf of a Member, filed a complaint or appealed a decision of MDG.

Dentist Network and Service Area

You will find a copy of the MDG Directory of Participating Dental offices in your enrollment package. This directory shows the network coverage and lists the Participating General Dentists (Primary Care Dentists) in your area. You can select a primary care dentist convenient to your home or workplace. If you have any questions, call the MDG Member Services Department for information or assistance.

Information For Members With Special Needs

If you have a disability affecting your ability to communicate or read, and you would like to request copies of these enrollment materials or the information describing the complaint and appeal process, please contact the Managed DentalGuard ("MDG") Member Services Department. You may request versions of these enrollment materials in Braille, audiotape, large print (17-point), TDD access or through an interpreter.

If you have special needs, such as a disability or chronic condition, and you would like assistance in determining appropriate courses of care to assure that health care services are available and accessible to you, please contact the MDG Member Services Department or complete the form below and send it to:

MDG Member Services Department
21255 Burbank Boulevard, Suite 120
Woodland Hills, CA 91367
Telephone (888) 618-2016
Fax # (818) 596-5891

Managed DentalGuard, Inc.
14643 Dallas Parkway, Suite 100
Dallas, TX 75254

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Managed DentalGuard, Inc.

Request for Materials and/or Special Needs Assistance

Name:

SSN#:

Address:

Daytime Telephone:

Evening Telephone:

Employer Name:

Plan #:

Materials Requested:

Braille _____ Interpreter _____ Audiotape _____

TDD Access _____ Large Print (17-point) _____

Special Needs Assistance requested for:

Disability _____ Chronic Condition _____

Other _____

Please explain _____

CDT Codes ++	Covered Dental Services	Patient Charges
D0999	Office visit during regular hours, general dentist only *	$0
	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 + =	0
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) ^	0
D9999	Sealant – per tooth (non-molars) ^	35
	Space Maintenance (Passive Appliances)	
D1510	Space maintainer – fixed - unilateral	0
D1515	Space maintainer – fixed - bilateral	0
D1525	Space maintainer – removable - bilateral	0
D1550	Re-cementation of space maintainer	0
D1555	Removal of fixed space maintainer	0
	Amalgam Restorations (Including Polishing)	
D2140	Amalgam – one surface, primary or permanent	0
D2150	Amalgam – two surfaces, primary or permanent	0
D2160	Amalgam – three surfaces, primary or permanent	0
D2161	Amalgam – four or more surfaces, primary or permanent	0
	Resin-Based Composite Restorations - Direct	
D2330	Resin-based composite – one surface, anterior	0
D2331	Resin-based composite – two surfaces, anterior	0
D2332	Resin-based composite – three surfaces, anterior	0
D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)	0
D2390	Resin-based composite crown, anterior	75
D2391	Resin-based composite – one surface, posterior	0
D2392	Resin-based composite – two surfaces, posterior	0
D2393	Resin-based composite – three surfaces, posterior	0
D2394	Resin-based composite – four or more surfaces, posterior	0
	Inlay/Onlay Restorations ^^	
D2510	Inlay – metallic – one surface **	265
D2520	Inlay – metallic – two surfaces **	320
D2530	Inlay – metallic – three or more surfaces **	350
D2542	Onlay – metallic – two surfaces **	350
D2543	Onlay – metallic – three surfaces **	360
D2544	Onlay – metallic – four or more surfaces **	370
D2610	Inlay – porcelain/ceramic – one surface	265
D2620	Inlay – porcelain/ceramic – two surfaces	320
D2630	Inlay – porcelain/ceramic – three or more surfaces	350
D2642	Onlay – porcelain/ceramic – two surfaces	350
D2643	Onlay – porcelain/ceramic – three surfaces	360
D2644	Onlay – porcelain/ceramic – four or more surfaces	370

CDT Codes ++	Covered Dental Services	Patient Charges
	Crowns – Single Restorations Only ^^	
D2740	Crown – porcelain/ceramic substrate	$395
D2750	Crown – porcelain fused to high noble metal **	375
D2751	Crown – porcelain fused to predominantly base metal	375
D2752	Crown – porcelain fused to noble metal	375
D2780	Crown – ¾ cast high noble metal **	365
D2781	Crown – ¾ cast predominantly base metal	365
D2782	Crown – ¾ cast noble metal	365
D2783	Crown – ¾ porcelain/ceramic	365
D2790	Crown – full cast high noble metal **	375
D2791	Crown – full cast predominantly base metal	375
D2792	Crown – full cast noble metal	375
D2794	Crown – titanium	375
	Other Restorative Services	
D2910	Recement inlay, onlay, or partial coverage restoration	0
D2915	Recement cast or prefabricated post and core	0
D2920	Recement crown	0
D2930	Prefabricated stainless steel crown – primary tooth	88
D2931	Prefabricated stainless steel crown – permanent tooth	88
D2932	Prefabricated resin crown	108
D2933	Prefabricated stainless steel crown with resin window	108
D2934	Prefabricated esthetic coated stainless steel crown – primary tooth	115
D2940	Sedative filling	0
D2950	Core buildup, including any pins	100
D2951	Pin retention – per tooth, in addition to restoration	18
D2952	Post and core in addition to crown, indirectly fabricated	155
D2953	Each additional indirectly fabricated post – same tooth	79
D2954	Prefabricated post and core in addition to crown	125
D2957	Each additional prefabricated post – same tooth	51
D2960	Labial veneer (resin laminate) – chairside	250
D2970	Temporary crown (fractured tooth)	86
D2971	Additional procedures to construct new crown under existing partial denture framework	125
	Pulp Capping	
D3110	Pulp cap – direct (excluding final restoration)	0
D3120	Pulp cap – indirect (excluding final restoration)	0
	Pulpotomy	
D3220	Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction and application of medicament	0
D3221	Pulpal debridement, primary and permanent teeth	0
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	0
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	0
	Endodontic Therapy (Including Treatment Plan, Clinical Procedures And Follow-up Care)	
D3310	Root canal, anterior (excluding final restoration)	120
D3320	Root canal, bicuspid (excluding final restoration)	145
D3330	Root canal, molar (excluding final restoration)	270
D3331	Treatment of root canal obstruction; non-surgical access	0
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	75
D3333	Internal root repair of perforation defects	116
	Endodontic Retreatment	
D3346	Retreatment of previous root canal therapy – anterior	375
D3347	Retreatment of previous root canal therapy – bicuspid	425
D3348	Retreatment of previous root canal therapy – molar	525
	Apicoectomy/Periradicular Services	
D3410	Apicoectomy/periradicular surgery – anterior	240
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	270
D3425	Apicoectomy/periradicular surgery – molar (first root)	320
D3426	Apicoectomy/periradicular surgery (each additional root)	116
D3430	Retrograde filling – per root	72
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	200
D4211	Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant	60
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant	240
D4241	Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant	144
D4249	Clinical crown lengthening – hard tissue	280
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces per quadrant	380
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces per quadrant	230
D4268	Surgical revision procedure, per tooth	0
D4270	Pedicle soft tissue graft procedure	350
D4271	Free soft tissue graft procedure (including donor site surgery)	363
D4273	Subepithelial connective tissue graft procedures, per tooth	399

CDT Codes ++	Covered Dental Services	Patient Charges
	Non-Surgical Periodontal Service	
D4341	Periodontal scaling and root planing – four or more teeth per quadrant	$0
D4342	Periodontal scaling and root planing – one to three teeth per quadrant	0
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	0
	Other Periodontal Services	
D4910	Periodontal maintenance, for the first two services in any 12-month period + #	0
D4920	Unscheduled dressing change (by someone other than treating dentist)	0
D4999	Periodontal maintenance, each additional service in same 12-month period + #	60
	Complete Dentures (Including Routine Post-Delivery Care)	
D5110	Complete denture – maxillary	452
D5120	Complete denture – mandibular	452
D5130	Immediate denture – maxillary	492
D5140	Immediate denture – mandibular	492
	Partial Dentures (Including Routine Post-Delivery Care)	
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	381
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	443
D5213	Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500
D5214	Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	500
D5225	Maxillary partial denture – flexible base (including any clasps, rests and teeth)	575
D5226	Mandibular partial denture – flexible base (including any clasps, rests and teeth)	575
	Adjustments to Dentures	
D5410	Adjust complete denture – maxillary	0
D5411	Adjust complete denture – mandibular	0
D5421	Adjust partial denture – maxillary	0
D5422	Adjust partial denture – mandibular	0
	Repairs To Complete Dentures	
D5510	Repair broken complete denture base	40
D5520	Replace missing or broken teeth – complete denture (each tooth)	36
	Repairs To Partial Dentures	
D5610	Repair resin denture base	44
D5620	Repair cast framework	80
D5630	Repair or replace broken clasp	56
D5640	Replace broken teeth – per tooth	36
D5650	Add tooth to existing partial denture	52
D5660	Add clasp to existing partial denture	64
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	196
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	196
	Denture Rebase Procedures	
D5710	Rebase complete maxillary denture	160
D5711	Rebase complete mandibular denture	160
D5720	Rebase maxillary partial denture	160
D5721	Rebase mandibular partial denture	160
	Denture Reline Procedures	
D5730	Reline complete maxillary denture (chairside)	88
D5731	Reline complete mandibular denture (chairside)	88
D5740	Reline maxillary partial denture (chairside)	88
D5741	Reline mandibular partial denture (chairside)	88
D5750	Reline complete maxillary denture (laboratory)	120
D5751	Reline complete mandibular denture (laboratory)	120
D5760	Reline maxillary partial denture (laboratory)	120
D5761	Reline mandibular partial denture (laboratory)	120
	Interim Prosthesis	
D5820	Interim partial denture (maxillary)	175
D5821	Interim partial denture (mandibular)	175
	Other Removable Prosthetic Services	
D5850	Tissue conditioning, maxillary	36
D5851	Tissue conditioning, mandibular	36
	Fixed Partial Denture Pontics ^^	
D6210	Pontic – cast high noble metal **	350
D6211	Pontic – cast predominantly base metal	350
D6212	Pontic – cast noble metal	350
D6214	Pontic – titanium	350
D6240	Pontic – porcelain fused to high noble metal **	350
D6241	Pontic – porcelain fused to predominantly base metal	350
D6242	Pontic – porcelain fused to noble metal	350
D6245	Pontic – porcelain/ceramic	360
	Fixed Partial Denture Retainers – Inlays/Onlays ^^	
D6600	Inlay – porcelain/ceramic – two surfaces	320
D6601	Inlay – porcelain/ceramic – three or more surfaces	350
D6602	Inlay – cast high noble metal, two surfaces **	320
D6603	Inlay – cast high noble metal, three or more surfaces **	350
D6604	Inlay – cast predominantly base metal, two surfaces	320

CDT Codes ++	Covered Dental Services	Patient Charges
	Fixed Partial Denture Retainers – Inlays/Onlays ^^ (continued)	
D6605	Inlay – cast predominantly base metal, three or more surfaces	$350
D6606	Inlay – cast noble metal, two surfaces	320
D6607	Inlay – cast noble metal, three or more surfaces	350
D6608	Onlay – porcelain/ceramic, two surfaces	350
D6609	Onlay – porcelain/ceramic, three or more surfaces	360
D6610	Onlay – cast high noble metal, two surfaces **	350
D6611	Onlay – cast high noble metal, three or more surfaces **	360
D6612	Onlay – cast predominantly base metal, two surfaces	350
D6613	Onlay – cast predominantly base metal, three or more surfaces	360
D6614	Onlay – cast noble metal, two surfaces	350
D6615	Onlay – cast noble metal, three or more surfaces	360
D6624	Inlay – titanium	320
D6634	Onlay – titanium	350
	Fixed Partial Denture Retainers – Crowns ^^	
D6740	Crown – porcelain/ceramic	395
D6750	Crown – porcelain fused to high noble metal **	375
D6751	Crown – porcelain fused to predominantly base metal	375
D6752	Crown – porcelain fused to noble metal	375
D6780	Crown – ¾ cast high noble metal **	365
D6781	Crown – ¾ cast predominantly base metal	365
D6782	Crown – ¾ cast noble metal	365
D6783	Crown – ¾ porcelain/ceramic	365
D6790	Crown – full cast high noble metal **	375
D6791	Crown – full cast predominantly base metal	375
D6792	Crown – full cast noble metal	375
D6794	Crown – titanium	375
	Other Fixed Partial Denture Services	
D6930	Recement fixed partial denture	36
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	155
D6972	Prefabricated post and core in addition to fixed partial denture retainer	125
D6973	Core build up for retainer, including any pins	100
D6976	Each additional cast post – same tooth	79
D6977	Each additional prefabricated post – same tooth	51
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	0
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0
	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	30
D7220	Removal of impacted tooth – soft tissue	114
D7230	Removal of impacted tooth – partially bony	140
D7240	Removal of impacted tooth – completely bony	160
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	200
D7250	Surgical removal of residual tooth roots (cutting procedure)	35
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	50
D7285	Biopsy of oral tissue – hard (bone, tooth)	60
D7286	Biopsy of oral tissue – soft	50
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	125
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	65
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	150
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	105
	Surgical Excision Of Intra-Osseous Lesions	
D7450	Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 cm	180
D7451	Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 cm	289
	Excision Of Bone Tissue	
D7471	Removal of lateral exostosis (maxilla or mandible)	204
D7472	Removal of torus palatinus	283
D7473	Removal of torus mandibularis	283
	Surgical Incision	
D7510	Incision and drainage of abscess – intraoral soft tissue	25
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	30
	Other Repair Procedures	
D7960	Frenulectomy (frenectomy or frenotomy) – separate procedure	133
D7963	Frenuloplasty	163

CDT Codes ++	Covered Dental Services	Patient Charges
	Unclassified Treatment	
D9110	Palliative (emergency) treatment of dental pain – minor procedure	$0
D9120	Fixed partial denture sectioning	15
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)	0
	Professional Visits	
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	0
D9440	Office visit – after regularly scheduled hours	50
D9450	Case presentation, detailed and extensive treatment planning	0
	Miscellaneous Services	
D9951	Occlusal adjustment – limited	10
D9971	Odontoplasty – one to two teeth	10
D9972	External bleaching – per arch	165
	Broken appointment	25

+ 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 10004 2008-6567

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	Maximum Rollover Account Limit
$5000	$1000	$500	$1500
Maximum claims reimbursement	Claims amount that determines rollover eligibility	Additional dollars added to Plan Annual Maximum for future years	Plan Annual Maximum plus Maximum Rollover cannot exceed $6,500 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.

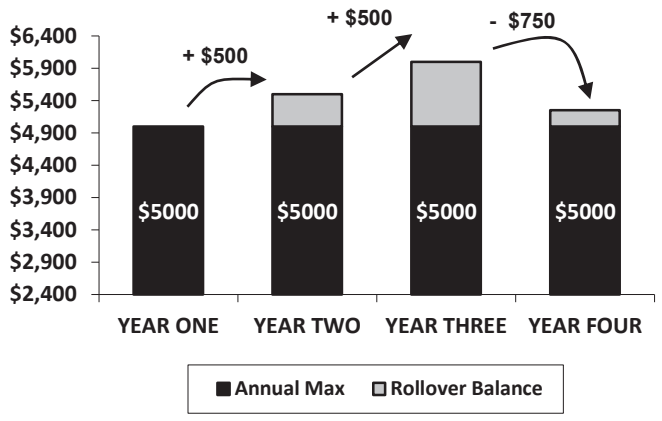
Here's how the benefits work:

YEAR ONE: Jane starts with a $5,000 Plan Annual Maximum. She submits $150 in dental claims. Since she did not reach the $1,000 Threshold, she receives a $500 rollover that will be applied to Year Two.

YEAR TWO: Jane now has an increased Plan Annual Maximum of $5,500. This year, she submits $50 in claims and receives an additional $500 rollover added to her Plan Annual Maximum.

YEAR THREE: Jane now has an increased Plan Annual Maximum of $6,000. This year, she submits $3,750 in claims. All claims are paid due to the amount accumulated in her Maximum Rollover Account.

YEAR FOUR: Jane's Plan Annual Maximum is $5,250 ($5,000 Plan Annual Maximum + $250 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®

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

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/PrivacyPolicy

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 LTC 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. For example, we may use your PHI for underwriting and premium rating purposes.

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 act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your 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. A breach means the acquisition, access, use, or disclosure of 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, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- 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 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, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may 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).
- Guardian 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 disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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, (ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

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

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

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

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of the 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. Your request must 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).

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.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary 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.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. 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 group term life, accidental death and dismemberment, Short term disability, Long term disability, critical illness, dental, vision, and accident coverages.
Managed DentalGuard, Inc., a subsidiary of The Guardian Life Insurance Company of America
Managed DentalGuard, Inc., underwrites group pre-paid dental coverages.

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

Enrollment/Change Form

Please print clearly and mark carefully.

Employer Name: **CITY OF COPPELL**	Group Plan Number: **00459930**	Benefits Effective:_____

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

Class: ALL ELIGIBLE FULL TIME EMPLOYEES WORKING AT LEAST 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 dependent tax exemption. Dependent 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.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone: ( ) -		Gender ❑ M ❑ F	Social Security Number _____ - _____ - _____ 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: Jun 30, 2016

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.**

	Employee Only	EE & Spouse	EE & Dependent/Child(ren)	EE, Spouse & Dependent/Child(ren)
Option 1: DHMO	❑	❑	❑	❑
Option 2: PPO	❑	❑	❑	❑

- **If DHMO 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.
- 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.
- 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.

Guardian Group Plan Number: **00459930** Please print employee name:

- I acknowledge and consent to receiving electronic copies of applicable insurance 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 with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

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** _____

Enrollment Kit 00459930, 0001, EN

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

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.

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.

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

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.