DENTALGUARD PREFERRED NETWORK Dentist Manual

DENTALGUARD PREFERRED NETWORK DENTIST MANUAL
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I: INTRODUCTION

Welcome to Guardian's DentalGuard Preferred Network. We are pleased that you are participating with us to deliver quality dental care to our members.

The DentalGuard Preferred Network Dentist Manual ("Manual") was created to answer your questions and provide a guide to assist you in the handling of claims for your DentalGuard patients.

We encourage you to call our Network Services Department at 1-800-890-4774, during regular business hours for questions regarding your Dentist Agreement or Fee Schedule.

You can access benefit information for your Guardian patients instantly at **www.GuardianAnytime.com**. You may also contact our Customer Service Delivery Department by calling 1-800-541-7846, if you have questions regarding a specific claim payment, eligibility or plan benefit.

DentalGuard Select Network

Most of the dentists in the DentalGuard Preferred Network are also in the DentalGuard Select Network. The DentalGuard Select Network is the name of the network available to other payers, including Third Party Administrators (TPA) who process claims for large self-funded or self-administered employer groups, unions, and other insurance carriers. For a list of current payers, please call 1-888-600-2580. The covered members of these plans are encouraged to obtain their dental care from DentalGuard Select Network Dentists.

Important Note: *Patients with plans that access the Select Network are* ***not*** *Guardian members, nor are these Guardian administered plans.*

The member's Identification Card ("ID Card") provides the address to submit claims and the telephone number to call for benefit and eligibility information. Each group's ID Card should indicate the "DentalGuard Select Network," when applicable.

Reimbursement is based on 100% of the Guardian's Fee Schedule amount. It is advisable to call the number on the member's ID Card to verify a member's eligibility and specific plan provisions.

This Manual provides policy and procedural information for the DentalGuard Plans administered by Guardian.

Dental plans that access the DentalGuard Select Network may be administered differently than described in this Manual.

II. QUICK REFERENCE GUIDE

We are providing you with a Quick Reference Guide to assist you in quickly finding answers and information you need about the DentalGuard Preferred Network.

Physical Location/Street Address:	The Guardian Life Insurance Company of America Suite 300, 605 East Holland Avenue Spokane, WA 99218
Network Services' Mailing Address:	The Guardian Life Insurance Company of America Network Services PO Box 981574 El Paso, TX 79998-1574
Network Services' Hours of Operation:	Monday – Friday 5:00 a.m. – 6:00 p.m. (Pacific Standard Time)
Network Services: Contact our Network Services Department for information regarding your Dentist Agreement or Fee Schedule.	(800) 890-4774 (509) 468-6550 (Fax)
DentalGuard Website:	**http://www.guardianlife.com**
Guardian Anytime Online:	**www.GuardianAnytime.com**
Customer Service Delivery Department Hours of Operation:	Monday – Friday 5:00 a.m. – 6:00 p.m. (Pacific Standard Time)
Customer Service Delivery Department: Contact our Customer Service Delivery Department for information regarding your patient's eligibility, benefits, or claims.	(800) 541-7846 (509) 468-6123 (Fax)
DentalGuard Claim Payment Mailing Address:	The Guardian Life Insurance Company of America PO Box 981572 El Paso, TX 79998-1572

III. FREQUENTLY ASKED QUESTIONS AND ANSWERS

Q. How do I identify a DentalGuard PPO member?

A. At the time of enrollment, DentalGuard or DentalGuard Select ID Cards are issued and contain the DentalGuard Preferred Network and member's name, Group/Plan number and claim address. The ID Card may not be current and is not intended to provide eligibility verification.

Q. How do I verify a member's eligibility?

A. Utilize the telephone number on the ID Card to verify the eligibility status of a member.

Q. How will I be compensated for my services as a contracted dentist in the DentalGuard Preferred Network?

A. The contracted dentist should submit all dental claims, whether treatment is covered or not, to Guardian for consideration and/or reimbursement. Guardian will send an explanation of benefits to the member and the dentist. Reimbursement will be sent directly to the contracted dentist.

Q. What if a patient requires specialty dental care services?

A. If treatment by a dental specialist is necessary, the member may choose to see any specialist. If they wish to see a DentalGuard Preferred Specialist, they can choose a specialist from the Guardian website (www.GuardianAnytime.com) or by calling the Customer Service Delivery Department at 1-800-541-7846. The member is not required to obtain written approval from Guardian prior to selecting or receiving treatment from a specialist.

Q. Do all dentists who want to participate need to sign a Dentist Agreement or just the owner of the practice or corporation?

A. Dentists are credentialed individually. Each dentist must complete an application, sign the Dentist Agreement and be approved by Guardian.

Q. Does the Dentist Agreement renew yearly?

A. The Dentist Agreement will automatically renew for a subsequent twelve (12) month period unless terminated by the dentist or Guardian.

Q. How do I terminate my Guardian Dentist Agreement?

A. Terminating your Dentist Agreement with Guardian requires a written, "legal notice" which should be sent return receipt requested, to:

The Guardian Life Insurance Company of America
P.O. Box 981574, El Paso, TX 79998-1574
Attn: Network Services

Terminations from the DentalGuard Preferred Network shall be effective ninety (90) days from the date Guardian receives the letter or in accordance with state regulations.

Q. How often are the Fee Schedules updated?

A. Fee Schedules are reviewed every thirty-six (36) to forty-eight (48) months. Fee schedule revisions are made when required.

Q. What if a procedure and fee is not listed on the Fee Schedule?

A. The listing of codes on the Fee Schedule is not a guarantee of coverage. CDT codes not listed on the Fee Schedule may be charged at your usual fee. Guardian reserves the right to apply comparable Fee Schedule amounts resulting from revisions to CDT Codes.

Q. Are the benefits the same for all members?

A. Plan provisions, limitations, coinsurance percentages and deductibles, etc., vary and should be confirmed by calling the number listed on the member's ID Card.

Q. How does a DentalGuard plan work?

A. A DentalGuard plan is a discounted Fee-For-Service Plan. The contracted dentist agrees to adhere to a Fee Schedule, which represents the maximum allowable charge payable by Guardian, the member and/or another payer. Contracted dentists shall look solely to the applicable Payer for such compensation and shall not seek compensation from covered individuals, except for applicable co-payments, deductibles, or services not covered in whole or part, under the member's Dental Plan.

IV. DENTALGUARD PLAN/NETWORK SERVICES

DentalGuard Plans (PPO)

DentalGuard plans are designed to provide high quality dental care while controlling the cost of such care. To do this, the plan encourages a member to seek dental care from dentists and dental care facilities that are contracted with Guardian's DentalGuard Preferred Network.

Contracted Dentist

A "Contracted Dentist" is a dental practitioner or a dental facility that is under contract with Guardian, its subsidiaries, or a third party with whom Guardian contracts.

Upon enrollment, members receive a dental plan ID Card; Guardian's website (www.GuardianAnytime.com) lists most contracted dentists.

Fee Schedules

Contracted dentists have agreed to accept the Fee Schedule amount as payment in full for services rendered. Contracted dentists may only charge covered individual's applicable co-payments, deductibles, or for services not covered, in whole or part, under the applicable Dental Plan.

Contracted dentists usually prepare claim forms for the member and submit the forms to Guardian. The member and the dentist will receive an explanation of benefits (EOB) statement explaining the plan's benefit payments. Guardian sends the payable benefits directly to the contracted dentist.

If a member is incorrectly determined to be ineligible, the dentist shall promptly reimburse (or adjust) the member for any payments received (or due) from the member over the appropriate amounts due pursuant to the Dentist Agreement and EOB.

Network Services Department

Guardian's Network Services Department strives to maintain a professional working relationship with contracted dentists by providing timely assistance in all situations.

The Network Services Department is available to answer questions regarding your Dentist Agreement, Fee Schedule and questions regarding patient billing.

The Network Services Department's address and telephone number are in the Introduction and Quick Reference Guide sections of this Manual.

V. ADMINISTRATION

Verifying Eligibility

Covered Individuals

All members with dental coverage are provided an ID Card. When a DentalGuard member comes to your office for the first time, the member's ID card should be presented or requested.

Member ID Card

The member's ID card indicates whether the member is enrolled in a DentalGuard Network (Guardian administered) or DentalGuard Select Network (third party administered) plan. The ID card provides the address and telephone number for claim payment information.

Customer Service Delivery Department

Information regarding eligibility, plan benefits and plan provisions for Guardian members can be accessed at **www.GuardianAnytime.com** or by calling our Customer Service Delivery Department at 1-800-541-7846.

Integrated Voice Response (IVR) System

Our Customer Service Delivery Department menu offers several selections to obtain dental eligibility. One (1) option is the Interactive Voice Response (IVR) System. This is an automated system used to check patient eligibility, plan benefits and claim status. Please contact our Customer Service Delivery Department at 1-800-541-7846 and follow the instructions for the IVR System.

If the information cannot be retrieved by the automated system, you will be connected to a Customer Service Delivery Department Member Specialist.

Benefits Via Fax

If you have a fax machine, you can take advantage of Guardian's Description of Benefits Summary Statement via Fax. To utilize this option, call 1-800-541-7846 and have the following information available:

- Member's social security number or unique identification number

To obtain **Family information,** choose **Option 1**. To obtain **Individual information,** choose **Option 2**.

A faxed "Description of Benefits Summary" will automatically be sent, usually within thirty (30) minutes. This summary will include the effective date(s) of coverage, family or individual coverage, and dependent age limits.

The "Benefit Summary" will provide general information about the plan benefits, such as co-insurance and deductible amounts. It will also advise allowed frequency limitations for services such as oral exams/evaluations, prophylaxes, radiographs and periodontal scaling and root planing.

All services rendered are subject to the patient's plan provisions, the fee schedule and the Dentist Agreement.

Check Status of a Dental Claim:

To check the status of a dental claim you will need the following information:

- Member's social security number or unique identification number
- Patient's date of birth – (e.g., 01/01/1950)
- Date of patient's service – (e.g., 06/01/2019)

To obtain a **Predetermination of Benefits**, choose **Option 1**. To check the status of a **Date of Service(s)**, choose **Option 2**.

If you have received the requested information and have any additional questions, please contact our Customer Service Delivery Department at 1-800-541-7846.

Dentist Information Services

Accurate information for each contracted dentist is critical to the efficient administration of a DentalGuard Plan. Please submit the following changes in writing to our Network Services Department at the address shown in the Quick Reference Guide Section or fax the information to 1-509-468-6550.

Adding an Associate Dentist

When adding an associate, please contact our Network Services Department. The dentist will be required to meet all requirements of the Credentialing Process and be approved by Guardian if the associate is not already contracted with us. If the associate is contracted through Guardian at another location, we only need a written authorization to change, add, or delete their existing address.

Adding a Practice Location

If the contracted dentist opens an additional office(s) or facility, please send or fax us a letter with the office address, office telephone number, the tax identification number(s) and W9 form for each location to be used for claim submissions.

If the contracted dentist is opening an additional office(s) or facility in a different state, the dentist will be required to go through the Credentialing Process for approval.

Dentist Directory

Guardian provides a listing of contracted dentists on our website at **www.guardianlife.com**.

Please visit this website when a patient requests a referral to a DentalGuard Preferred Specialist. You may also visit this website to view your own network listing.

Please notify our Network Services Department, in writing, of any changes in address, telephone number, tax identification number, or to add additional locations or associates.

Closing to New Enrollment

You may limit the number of patients referred to your practice at any time. Notify our Network Services Department in writing and your name will be identified in the directory with an asterisk indicating that your office is closed to new patients.

Terminating Your Dentist Agreement

The DentalGuard Preferred Dentist Agreement may be terminated at any time upon written "legal notice" sent to Guardian. Such termination shall be effective ninety (90) days from the date Guardian receives the letter or in accordance with state regulations. The termination request must be signed by the dentist.

Terminating your Dentist Agreement with Guardian requires a written "legal notice" which should be sent return receipt requested to:

The Guardian Life Insurance Company of America
Network Services Department
P.O. Box 981574
El Paso TX 79998-1574

As a courtesy to your patients, you should notify DentalGuard members that you are no longer a contracted dentist.

Selling a Practice or Retiring from Dentistry

If a DentalGuard dentist elects to sell a practice contracted with Guardian, he or she should notify Guardian in writing no later than thirty (30) days after the transaction. Documentation should include the last date of practice. If the new owner chooses to participate in the DentalGuard Preferred Network, he or she will need to complete his or her own application and undergo the credentialing process.

Buying a Practice

Accurate information is crucial to the administration of a DentalGuard Plan. If a contracted dentist acquires a new practice and wants the new location listed under their original Dentist Agreement, they should notify Guardian, in writing, no later than thirty (30) days after the transaction. Written documentation should include the complete address, tax identification number, and telephone number. (Please see the Quick Reference Guide for Network Services' mailing address and/or fax number.)

Electronic Funds Transfer (EFT)

To register for claim payments to be deposited directly into the bank account of your choice, contact Change Healthcare (formerly Emdeon) at 866-506-2830, and select **Option 1** to begin the ePayment enrollment process or go to **www.emdeon.com/epayment** or **www.GuardianAnytime.com.**

Virtual Credit Card

As part of our ongoing commitment to simplify and improve payment transactions for your business, Guardian Life Insurance Company has partnered with Change Healthcare and ECHO Health, Inc. to offer provider reimbursement via virtual credit card payment. To enroll in this service, please contact ECHO Health, Inc. via the following URL, https://www.changehealthcare.com/support/customer-resources/enrollment-services, or by calling (888) 456-0381.

Credentialing Process

The objective of our credentialing process is to exercise reasonable care in the selection and retention of qualified contracted dentists who will render dental services to our members.

Dentist Application Review Process

Prior to executing a dentist agreement, Guardian will review the credentials of the applicant dentist. Guardian will review the information provided on the Dentist Application, and confirm verification of a current valid license, state license sanctions, valid Drug Enforcement Agency Certificate, graduation from an accredited dental school, identity of the institution at which specialty training was completed, if applicable, confirmation of malpractice insurance coverage in force, malpractice claim history, practice work history over at least the last five (5) years and an attestation by the dentist to certain information, such as pending malpractice actions, health status as it relates to the practice of dentistry and OSHA compliance.

Guardian will also review the policies implemented by the office for handicap access and after-hour emergencies.

The application may be accepted or denied as a result of this review process.

Dental Applicant License Status Review

Prior to activation, Guardian will need the following documents:

- A signed and dated Dentist Agreement from each dentist in the dental office.
- A Guardian application form completed, signed and dated by each dentist in the dental office.
- Copy of the current state dental license for each dentist. (verified through the state dental board)
- Copy of the declarations page of the current professional liability insurance policy for each dentist.
- Copy of DEA certificate and/or state CDS. (verified through National Technical Information Service)

For each dentist application, an inquiry will be made to the:

- State Licensing Board
- National Practitioner Data Bank (“NPDB”)

Guardian queries the NPDB for each applicant dentist at the time of initial credentialing and for contracted dentists at the time of recredentialing.

Guardian is required by law to file a report with the NPDB regarding any dentist not accepted into the network, or is terminated from the network, when the reason is related to the practitioner's professional competence and results in a decision that adversely affects his or her clinical privileges.

If Guardian reverses the decision to not accept a dentist into the network, or to terminate a network dentist, Guardian will request that any NPDB report previously filed based on the above reason be deleted from the NPDB.

Primary source verifications will be made, but not limited to, NPDB and state licensure boards. The purpose of the verification procedure is to:

- Corroborate the applicant's statements in the dentist questionnaire.
- Verify that the applicant is licensed.
- Verify current good standing of the license.
- Check for any past disciplinary actions.

Claim Submissions

- All dental claim forms should be mailed directly to the address listed on the member's ID Card.

- Guardian accepts any standard dental claim form, as well as submission through an electronic clearinghouse, such as Change Healthcare (formerly Emdeon) or Dentalxchange.

Clean Claim Definition

Guardian defines a clean dental claim as follows:

A claim submitted for payment of covered dental services that can be processed without the need for any additional information. The claim must be submitted on a dental claim form, with all data elements completed.

A claim is not clean, if it requires Guardian to: 1) obtain additional information from the dentist or patient, including, but not limited to, primary carrier vouchers, medical vouchers, radiographs and patient or dentist information; 2) obtain information on student eligibility or on over-age dependents; or 3) investigate possible fraud or misrepresentation of information.

A clean claim must include the following data elements:

- Patient name (First name, middle initial, last name)
- Patient date of birth
- Patient complete address
- Patient gender
- Patient relationship to insured/employee
- Patient marital status
- Other health insurance coverage information (Other insured name, date of birth, gender, Insurance Company name, Policy/Group number, Employer name, or School name)
- Insured/Employee name (First name, middle initial, last name)
- Insured/Employee date of birth
- Insured/Employee social security number/unique identification number
- Insured/Employee Policy/Group number

- Insured/Employee employer name
- Insured/Employee complete address
- Dentist name (First name, middle initial, last name)
- Dentist complete address and telephone number
- Date(s) of service, CDT code, description of service, tooth number, arch or quadrant, surface codes, fee charged, applicable radiographs and pocket depth probing, by report ADA code narratives
- Dentist signature and date
- Indication if service is a result of an accident or work related (If result of an accident, major medical vouchers will be requested and benefits will be coordinated)
- Indication if a prosthetic device/appliance is initial or a replacement and if replacement, the initial placement date

For orthodontic services the following data elements must be submitted in addition to the prior data requirements:

- Orthodontic total treatment fee
- Orthodontic total number of estimated months of treatment
- Orthodontic date of service when appliance is placed

If it is determined that the submitted claim is not a “clean claim,” any additional information needed to process the claim will be requested in writing.

Electronic Claim Submission

For faster claim processing you may submit claims electronically using Guardian’s Payer ID # 64246.

If you have questions regarding electronic claim submission, please contact Network Services at 800-890-4774.

Dentist Identification Number

Your dentist identification number is your Federal Tax Identification Number and your National Provider Identifier (NPI) number. To ensure proper claim payment, these numbers should be used on all claim forms and correspondence. When filing a claim under a group practice or facility name, the dentist providing treatment must include his/her name on the claim form.

Pre-Determination/Pre-Treatment Review

The member and dentist may have services, or a treatment plan reviewed and considered for available benefits prior to beginning treatment. Pre-treatment review is not a guarantee of what Guardian will pay. It tells the member and their dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. Payment is contingent on; a) the work being done as proposed and while the member is insured; and b) application of the deductible and payment limit provisions and all of the other terms of the member’s plan.

Guardian will review the services, with the provided supporting documentation and the estimate of available benefits will be sent to the member and/or the member’s dentist.

Claims submitted for pre-treatment review are handled and processed the same as claims submitted with dates of service. Since no dates of service are submitted on a predetermination, Guardian will assume that all services submitted may be performed on the same day. For this reason, if the contracted dentist is intending to submit two different treatment plans, or an initial phase of treatment, (such as scaling and root planing, followed by osseous surgery), the treatment plans should indicate this on the submitted claim form.

Pre-treatment review is strongly recommended, but not required, for any/all services that are listed in the section below, and/or for extensive treatment plans.

Claim Review

In order to accurately pay for and determine covered benefits, Guardian reserves the right to require acceptable diagnostic documentation for any service received on a claim. If the necessary information is not provided, no benefit or minimum benefit may be allowable.

Although Guardian reserves the right to review any claim, Guardian typically requires documentation for clinical pre-payment review by our Dentist Reviewers for the services:

- Onlays (D2542-D2544, D2642-D2644, D2662-D2664)
- Crowns (D2710-D2794)
- Core Buildups / Post & Cores (D2950/D2952/D2954)
- Veneers (D2960-D2962)
- Treatment of Root Canal Obstruction (D3331)
- Gingivectomy/Gingivoplasty (D4210-D4211)
- Clinical Crown Lengthening (D4249)
- Osseous Surgery (D4260-D4261)
- Bone Replacement Graft (Perio) (D4263-D4264)
- Inlays (D2510-D2530, D2610-D2630, D2650-D2652)
- Periodontal Scaling and Root Planing (D4341-D4342)
- Bridges (D6205-D6794)
- Pediatric Fixed Partial Denture (D6985)
- Surgical Extractions (D7210, D7250)

In addition, Guardian has a utilization review-based claim program that selects random claims for pre-payment clinical review. Our Reviewing Dentists determine, based on the documentation submitted, if contractual policies have been met for benefit allowance.

Proof of Loss / Supporting Claim Documentation

Acceptable diagnostic documentation may, at Guardian's discretion, consist of:

- **Radiographs**: Submitted radiographs should be pre-operative, current (taken within twenty-four (24) consecutive months of the date of service), of diagnostic-quality and be identified with right or left side, the patient/member's name, the date taken and the provider's name. Please note that a Panoramic radiograph (alone) is considered to have limited diagnostic value for determination of services outside of oral surgery procedures.

- **Periodontal Charting**: Submitted periodontal charting should be comprehensive (documenting measuring points per tooth, furcation defects, mobility and any recession), current (recorded within twelve (12) consecutive months of the date of service), legible and identified with the patient/member's name, date recorded and the provider's name.
- **Progress/Chart Notes**: When radiographs and periodontal charting (when applicable) do not adequately document or support the necessity of a service, please submit a copy of progress and/or chart notes in addition to radiographs and periodontal charting (when applicable) for documentation and to support the necessity and appropriateness of treatment. Although not required, progress/chart notes can be extremely helpful adjuncts for appropriate claim determination. Please note that progress/chart notes alone are not sufficient to document the necessity of treatment.
- **Intra and Extra-oral photographs and Other Diagnostic Materials:** When radiographs and periodontal charting (when applicable) alone do not adequately document or support the necessity of a service, current, diagnostic-quality, labeled intra-oral photographs and other diagnostic materials (when available) may be submitted in addition to radiographs and periodontal charting (when applicable) to document the necessity and appropriateness of treatment. Although not required, intra-oral photographs can be extremely helpful adjuncts for appropriate claim determination. Please note that photographs alone may not be enough to document the necessity of treatment.

Radiographs will not be returned <u>unless</u> they are received with a self-addressed, stamped return envelope.

Please refer to the **Guardian Dental Practice Guidelines** for more CDT Code specific information and criteria used to determine benefits for covered services under the terms of the patient's contract.

Explanation of Benefits Statement ("EOB")

If you have questions regarding the explanation of benefits (EOB) statement or the member's patient responsibility, please contact our Customer Service Delivery Department at 1-800-541-7846.

<u>Complaint/Grievance and Arbitration Processes</u>

Complaint/Grievance Process

It is generally recognized that grievances may be classified into two categories:

<u>Administrative Services:</u>

Financial, procedural matters, medical (dental) necessity, claim payment or benefit terms.

A dentist or member who has questions, concerns, or wishes to appeal the benefit issued on a claim may request, in writing, that Guardian review the claim payment determination. The request should be directed to Guardian's Grievance Department at P.O. Box 981573, El Paso, Texas, 79998-1573 or via facsimile at 1-509-468-6399. The request should include the following information: copies of all relevant dental records, radiographs, and statements from the dentist or the office personnel. Many states also offer an external review process to their insured's and providers.

If Guardian has reached a final decision and the member is still dissatisfied, they have the right to file a complaint with their state's Insurance Commissioner. Guardian makes every attempt to resolve a claim situation directly with the member or dentist, while administering our dental plan provisions. A review of a claim or an appeal is handled in accordance with applicable state law requirements. A complaint may be handled in an initial call or may take longer if it requires review by a dentist consultant. Additional delays occur when information must be requested from the member or dentist.

Health Services – Complaints and Grievances Department:

Quality of care, standards of care, professional and ethical considerations.

In order to be responsive to a member's problems and concerns about coverage provided under the DentalGuard Preferred Network, the following grievance process has been established:

- Questions or concerns may be directed to our Customer Service Delivery Department either by telephone or by mail. When member issues or concerns are received by telephone, the Customer Service Delivery Department will work with the member to resolve the situation. If the member wishes to document the complaint in writing, the Customer Service Delivery Department requests that a Complaints and Grievances packet be mailed to the member. Guardian considers a grievance to be a complaint in writing. All written member complaints/grievances are investigated by the Complaints and Grievances Department.

- An acknowledgement letter is sent to the member indicating that a review is in process. The response time for a resolution is based on state requirements.

- Supporting documentation is collected on the complaint/grievance. A request may be made of the dental office to provide additional information, such as copies of all relevant dental records, radiographs, and statements.

- Upon receipt of complete documentation, the Complaints and Grievances committee determines a resolution based upon an objective evaluation. Quality of care complaints/grievances are resolved under the supervision of Guardian's Chief Dental Officer.

Arbitration Process

All disputes, controversies, or claims arising out of or relating to the interpretation of your dentist agreement with The Guardian Life Insurance Company of America, shall be settled by final and binding arbitration in accordance with the Commercial Arbitration Association, to the extent such rules are not inconsistent with this Agreement. Any award rendered by the arbitrators shall be final and binding upon the parties hereto and judgment upon any such award may be entered in any court having jurisdiction thereof. The fee and expenses of the arbitrators shall be borne equally by the parties. Each party shall pay its own fees and costs relating to any arbitral proceedings, including attorney's fees.

Appealing a Denied Claim or Service

If the member or dentist disagrees with the benefit determination, they have the right to appeal the denial or reduction of benefits for any claim or service. The member or dentist may send a written letter of appeal. When appropriate, Guardian will have the claim re-reviewed by a different dentist consultant, in compliance with applicable state laws. If not included with the appeal, we will request radiographs and any other information that supports the treatment. Based on the information submitted, the dentist consultant will review the claim and determine the benefit available for the service within the terms of the contract. If the original benefit determination is unchanged, a letter explaining the benefit will be sent to the member and/or dentist.

The dentist may request a courtesy call (Peer to Peer Call) from one of Guardian's reviewing dentists to review the criteria applied in the determination of the pre-determination or claim by indicating "Peer to Peer Call Request" and a phone number on the materials submitted.

VI. POLICIES AND PROCEDURES

Coordination of Benefits (COB)

Guardian coordinates benefits with other dental plans and with medical plans on some oral surgical procedures and procedures that are the result of an accident.

Coordination of Benefits applies when a member has other coverage under more than one plan ("dual coverage"). When a member has dental coverage under more than one plan, Guardian coordinates benefits with the benefits of all other plans so that benefits from these plans are not duplicated.

When coordinating with other dental plans, Guardian uses state guidelines in order to determine the primary plan. **The dentist's contracted fee schedule will apply even if Guardian is the secondary plan**. The total benefit Guardian will allow when added to the amount received from the primary plan will not exceed 100% of the dentist's contracted fee schedule amount with Guardian.

If it is determined, Guardian is the **primary plan**; the benefits will be based on Guardian's reimbursement amounts. When Guardian is the **secondary plan**, the benefit paid by Guardian will not exceed Guardian's reimbursement amount and will be reduced by the amount paid by the primary plan.

Coordination of benefits will be reflected on a date of service claim only.

When coordinating with a medical plan, the medical plan is considered the primary plan in most instances.

When Guardian is determined to be the **secondary plan**, Guardian requires a copy of the primary plan's explanation of benefits to be submitted to Guardian. If the primary plan pays no benefit, Guardian will provide the same benefits as if no other coverage exists.

As coordination of benefits may vary in some states, you may wish to contact our Customer Service Delivery Department at 1-800-541-7846, for additional information regarding your state's guidelines.

Determining the Primary/Secondary Plan

For Adults: A plan covering an adult as a member is primary and will determine benefits first. A plan covering an adult as a dependent (through a plan from a spouse's employer) is secondary and determines its benefits only after the primary plan's benefits have been paid. If a person is covered as a member or a former member under more than one plan, the plan which covers him/her as an active member determines benefits before any plan covering the person as a laid-off or retired member. Otherwise, the plan covering that person longer determines its benefits before the other plan does.

For Dependent Children: The determination of primary and secondary coverage for dependent children covered by two parent's plans follow the **birthday** or **gender rule**, depending on state regulations. When the birthday rule applies, the plan of the parent with the earlier birthday (month and day, not year) is primary; under the gender rule the father's plan is primary. Different rules apply for the children of custodial, divorced, or legally separated parent(s); contact our Customer Service Delivery Department at 800-741-7846, for additional information or if you have any questions.

DentalGuard Plan is the Primary Plan

When **a DentalGuard Plan is the primary plan** (e.g., a DentalGuard member also has a traditional plan or fee-for-service coverage under a spouse's plan), you may only bill the secondary carrier up to your Guardian fee schedule amount.

The member will be responsible for a payment only if Guardian's payment and the secondary plan's payment do not meet or exceed your Guardian fee schedule amount.

When a **DentalGuard Plan is the primary plan** and the secondary plan is a DHMO or prepaid dental plan, you may bill up to your Guardian fee schedule amount. Any benefit paid must be credited against the member's DHMO or prepaid patient charge or co-payment.

The member will be responsible for a payment only if Guardian's payment and the secondary plan's payment do not meet or exceed the member's DHMO or prepaid patient charge or co-payment or the dentist's Guardian fee schedule amount, whichever is less.

DentalGuard Plan is the Secondary Plan

When a **DentalGuard Plan is the secondary plan** (e.g. a DentalGuard member's spouse has traditional or fee-for-service coverage through his/her employer), you should bill the primary plan first.

The primary payment is then credited against the dentist's fee schedule amount. The amount paid by Guardian is then credited toward the remaining balance.

The member will be responsible for a payment only if the primary plan's payment and Guardian's payment do not meet or exceed the dentist's Guardian fee schedule amount.

When a **DentalGuard Plan is the secondary plan** and the primary plan is a DHMO or prepaid dental plan, you may only bill Guardian for the DHMO's patient charge or co-payment amount. Any payment made by Guardian must be credited against the member's patient charge or co-payment.

If the patient is covered under a DentalGuard Plan and a major-medical plan:

Some oral surgical procedures are also covered by major medical plans. In these instances, the medical plan is the primary plan over dental.

When a **DentalGuard Plan is the secondary plan** and the primary plan is a medical plan, bill the medical plan first. The medical plan's payment, if any, is then applied against the dentist's fee schedule amount. The amount paid by Guardian is then applied toward the remaining balance.

The member will be responsible for a payment only if the primary plan's payment and Guardian's payment do not meet or exceed the dentist's Guardian fee schedule amount.

Note: If the patient's major medical plan does issue a benefit for the surgical removal of impacted wisdom teeth, the explanation of benefits (EOB) must be submitted to Guardian with the claim. Guardian will coordinate benefits with the medical carrier. This information is not requested if a group has previously informed us that their medical carrier does not cover any dental procedures. Guardian does not request the major medical vouchers initially if a DentalGuard Preferred dentist performs the services. For those oral surgery procedures that are medical in nature, major medical vouchers will be requested. Guardian complies with the National Association of Insurance Commissioners (NAIC) guidelines when coordinating benefits.

Duplication of Records

Guardian recognizes that original patient records and radiographs are the property of the contracted dentist and are essential to planning treatment as well as verifying past treatment decisions. The original patient record, including original radiographs and study models should be retained in the dentist's office. Guardian dental plans do not cover radiograph duplication charges. The specified charge, if any, should be based on your office policy for all patients.

Radiographs are a part of the patient's clinical record and the dentist should retain the original images. Original images should not be used to fulfill requests made by patients or third parties for copies of records.

Appointment Guidelines

Appointment Scheduling

A preventive care appointment with a dentist should be available within three (3) to four (4) weeks of the patient's request. A routine care (follow-up) appointment should be available within two (2) to three (3) weeks of the patient's request. Members with dental emergencies should be seen within twenty-four (24) hours or on the same day, if medically indicated.

Broken/Missed Appointments

Guardian understands the value of patient treatment time and the financial impact that broken/missed appointments may have on a practice. The specified time and charge, if any, should be based on your office policy for all patients. Guardian dental plans do not cover charges for broken/missed appointments.

Emergency Care

Guardian defines emergency dental services as dental services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth.

Emergency Coverage

Contracted dentists should treat patients with emergencies within twenty-four (24) hours or on the same day, if medically indicated. A designated dental professional should be on call at all times for the handling of after-hours telephone inquiries involving dental emergencies or potential dental emergencies. This should include an expeditious telephone callback response from the designated dental professional to evaluate and appropriately direct the member's care. If a dental office does not provide after-office hours emergency availability, the dental office should advise all patients of record whom to contact should an emergency arise.

Vacation Coverage

Dentist on Vacation – If your office is closed for vacation, arrangements should be made to maintain twenty-four (24) hour emergency care access and to provide appropriate and timely emergency care for patients of record.

Member on Vacation – A member, who is not a regular patient of yours, may come to you on an emergency basis and should be treated as a new patient. Please contact our Customer Service Delivery Department at 800-541-7846 to verify eligibility.

Treatment Started by Another Dentist

Inlays, onlays, crowns, fixed bridges, laminate veneers, dentures, or root canal treatments that are initiated prior to the member's enrollment in Guardian's plan, are not covered. Guardian recommends that the dentist who started these procedures complete the procedures. If you agree to complete the procedure(s), you may charge your usual fee. If a predetermination or claim is submitted, the fee schedule amount will apply. The service(s) should be submitted to the prior carrier, as the service(s) must be started while the member is covered for Guardian to pay a benefit. (See the orthodontic section for exceptions to this guideline.)

The following criteria should be used to determine when a procedure has been started:

Root Canal Therapy - This procedure is considered to have been started when the pulp chamber has been opened.

If the pulp chamber was opened prior to the member's effective date or prior to the effective date of the DentalGuard plan, the root canal procedure is not a covered benefit and the contracted dentist may bill his or her usual fee. If a predetermination or claim is submitted, the fee schedule amount will apply

Crowns, Fixed Bridges and Other Cast Restorations - These procedures are considered to have been started when the tooth is prepared.

If the tooth is prepared prior to the member's effective date or prior to the effective date of the DentalGuard plan and a permanent restoration has not been placed, the procedure is not a covered benefit and the contracted dentist may bill his or her usual fee. If a predetermination or claim is submitted, the fee schedule amount will apply.

Dentures - This procedure is considered to have been started when the master impression is taken.

If a denture master impression is taken prior to the member's effective date of the DentalGuard plan, the procedure is not a covered benefit and the contracted dentist may bill his or her usual fee. If a predetermination or claim is submitted, the fee schedule amount will apply.

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Orthodontic Treatment - Please see the orthodontic section of this Manual.

Fee Schedule / Balance Billing

The fee schedule lists most of the services that may be covered under benefit plans covered by your Participating Dentist Agreement, as well as the maximum allowable amount that you may collect for such services.

Guardian reserves the right to modify CDT codes/CDT code sets and $0.00 pay codes based on the annual CDT code revisions made by the American Dental Association.

Guardian reviews the procedure codes and fee amounts on the fee schedule every thirty-six (36) to forty-eight (48) months. Fee schedule revisions are made when required.

You are required to accept the fee schedule amount as payment in full for all of the listed services that you provide that are covered under the terms of the patient's dental plan (these may be referred to as "Covered Services"). Reimbursement is based on 100% of the fee schedule amount, this amount may not necessarily represent the amount paid to you by Guardian for the Covered Services. The patient is responsible for the payment of any services that are not covered, any applicable deductible, co-payment amount and/or coinsurance amounts and any additional amount agreed to by the member/patient and you. These amounts can be collected from the patient, at the time the service is rendered.

You are also required to accept from the patient, the fee schedule amount as payment in full for all Covered Services that have exceeded a frequency or monetary limit contained in the patient's dental plan (e.g., prophylaxes that exceed the frequency limitations of a plan, or a procedure performed after a plan's annual maximum has been met).

Additionally, you are required to accept the fee schedule amount as payment in full from the patient for any listed services you provide that are not Covered Services due to specific coverage exclusions under the particular terms of the patient's plan, subject to any requirements of applicable state law.

Additional amounts that are billed based on an agreement with the patient/member should be presented to the patient/member in writing and signed by the patient/member signifying agreement to the additional billed amount by the member/patient.

Non-Covered Services

A patient's financial obligations should be provided to the patient/member prior to the delivery of services by a dentist who provides treatment in a state that has passed Non-Covered Service Legislation.

States that have approved Non-Covered Service Legislation prohibit us from requiring that a contracted dentist accept their agreed upon fee schedule (discount) amount, for any service that is never covered (non-covered) under the patient's/member's plan. This regulation applies to all dental plan types.

The determination of the patient responsibility for non-covered services, in these states, is based on the dentist's normal fee for the service. (Please refer to Appendix A for a list of states that have enacted laws with respect to the application of fee schedule limits to non-covered services as of the date this manual was published).

Examples of services that could fall into the "non-Covered Services" category include crowns, implants and orthodontics when excluded from coverage under a plan.

You may charge the patient your usual fee for services that are not listed on the fee schedule or listed with a $0.00 amount unless the services are considered part of a more comprehensive related service that is a listed service.

All benefit payments from Guardian will be sent directly to the contracted dentist.

Covered Charges

To be covered, a service must be necessary, appropriate for a given condition and follow the limitations and exclusions detailed in the listing of covered services in the member's certificate booklet. Guardian may use the professional review of a dentist consultant to determine the appropriate benefit for a dental procedure or course of treatment.

The contracted dentist has agreed to charge no more than the fee schedule amount for covered services and services usually covered by Guardian, where a benefit is not payable due to plan provisions and/or limitations.

Co-payments and Deductibles

Co-payments and deductibles are determined by the plan option purchased by the employer. Guardian offers a variety of dental plans to the employer with variable options. Please call for verification of specific plan benefits before rendering any treatment.

All members under a DentalGuard plan are issued a detailed policy booklet outlining the covered benefits and exclusions of their plan. Guardian highly recommends the predetermination process to determine the benefits payable.

Most Comprehensive Service

When a service is considered to be part of the most comprehensive procedure, the contracted dentist may not bill a patient separately for less comprehensive, related services that are considered to be part of the more comprehensive service.

When certain comprehensive dental procedures are performed, other less comprehensive, related procedures may be performed prior to, at the same time, or at a later date. For benefit purposes under this policy, these less comprehensive procedures are part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for such charges will be limited to the maximum benefit payable for the more comprehensive procedure.

For instance:

- The diagnostic and working radiographs taken at the time of root canal treatment, other than the initial periapical, are considered inclusive of the root canal procedure.
- All adhesives, bonding agents, liners, and bases are considered inclusive of the restoration performed.
- Isolation of a tooth with a rubber dam in conjunction with an endodontic or restorative procedure is considered inclusive of the endodontic or restorative procedure.

Least Expensive Alternate Treatment

If more than one type of service can be used to treat a dental condition, Guardian has the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice, as determined by Guardian. For example, in the case of multiple missing teeth, in both quadrants of an arch, the benefit may be based on the reimbursement for a removable partial denture.

In situations where a less expensive alternate benefit is given, the contracted dentist may balance bill the patient, up to the fee schedule amount for the actual service rendered. The benefit paid by Guardian will be based on the fee schedule amount of the least expensive professionally accepted service.

In all cases where there is more than one course of treatment available, the dentist should present a full disclosure of all the options to the member prior to treatment.

If the dentist and patient elect an acceptable dental service that is more expensive, the patient will be responsible for the difference between the fee schedule amount for the service performed and the benefit paid by Guardian, even if that benefit is based on a less expensive alternate procedure.

Informed Consent and Financial Agreement Forms for Non-Covered or Alternate Procedures

Although informed consent specifically involves the education of the patient, it also represents the final steps of developing a treatment plan. The process of informing the patient can be seen as a model for the dentist-patient relationship, one in which the dentist shares his or her knowledge, findings and recommendation as part of a cooperative effort to help the patient achieve a healthy oral condition.

If the patient selects a course of treatment that involves non-covered or alternate procedures, in order to maintain a positive relationship between you and your patient, Guardian recommends that the treatment plan be presented, in writing, and signed by the patient (or guardian, if under age 18) to assure that there is no confusion over the patient's treatment options, and/or financial responsibility. Disclosing all appropriate treatment alternatives to the patient (or guardian, if under age 18) greatly increases communication with the patient and reduces the dentist's professional liability, while reducing the likelihood of a misunderstanding.

After This Insurance Coverage Ends

Guardian will not pay for charges incurred after this insurance coverage ends. But, subject to all other terms of this plan, Guardian considers the following if the procedure is finished within thirty-one (31) days after this insurance coverage ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the insurance coverage ends; (b) any other appliance or dental prosthesis, if the master impression is made before the insurance coverage ends; and (c) root canal treatment, if the pulp chamber is opened before the insurance coverage ends.

Benefits for orthodontic treatment will only be paid to the end of the month in which the insurance coverage ends.

Quality Management Program

The purpose of Guardian's Quality Management Program ("QMP") is to measure and assess the quality of care that members receive from network dentists and the identification of opportunities to improve the quality of care and services rendered to members by network dentists and dentists accessed through a partner network. The scope of the QMP encompasses all structures, processes and outcomes necessary to meet Guardian's objectives to improve the quality of care and services that members receive. The primary components of the QMP are credentialing, re-credentialing and

complaint resolution.

The objectives of the Quality Management Program are:

1. To assure appropriate, quality care and satisfactory access to care and services for all members;
2. To coordinate all quality management activities into a well-integrated system which assures quality access;
3. To assure that dentist practices and professional performances are regularly and objectively assessed;
4. To assure the identification, investigation and resolution of problems that impact the care and services provided to members;
5. To require that the quality of care provided to members meets prevailing nationally recognized standards of care;
6. To recognize identified public health goals;
7. To evaluate the use of new technology or new use of existing technology;
8. To continually assess the effectiveness of the Quality Management Program.

Quality Management Committee

The purpose of the Quality Management Committee is to analyze, evaluate and resolve member complaints. Issues of a complex nature and quality of care issues may be presented to the Quality Management Committee at the discretion of the Dental Director or his or her Designee, or the Complaints and Grievances Department or his or her Designee, for review and resolution as needed.

The Complaints and Grievances Committee membership is comprised of the Dental Director or his or her Designee; the Team Leader, Complaints and Grievances Department or his or her Designee; legal counsel and Customer Service Delivery Department representatives, as needed.

Credentialing/Recredentialing Committee

The purpose of the Credentialing Committee is to review dentist applications, based on established criteria. The Credentialing Manager or his or her Designee, at the discretion of and in consultation with, the Dental Director or his or her Designee, may facilitate the review and preparation of documentation on any applicant or existing dentist and present the dentist's information to the Credentialing Committee.

The Credentialing Committee will be composed of the Dental Director or his or her Designee and the Credentialing Manager or his or her Designee.

VII. PLAN DESIGN

Plan Overview

Guardian offers many dental plans with both standard and variable options to the employer. Exclusions and Limitations may be revised to accommodate a plan holder's request. There are also plans that include waiting periods for categories of services and the benefit paid by Guardian can vary for each member.

Co-insurance, co-payments and deductibles are determined by the plan options chosen by the member's employer. Depending on the plan purchased by the member's employer, coverage for some dental procedures listed on the fee schedule may be excluded. All members are issued a detailed benefit booklet outlining the covered benefits, limitations and exclusions of their plan.

You may access patient benefit information online at **www.GuardianAnytime.com** or by contacting Guardian's Customer Service Delivery Department (800-541-7846) for verification of specific plan benefits or use the Benefit Statement via Fax option.

DG Alliance – Guardian offers the DG Alliance plan to planholders based on specific plan design options. If a member has a DG Alliance plan and the treating dentist is a DG Alliance contracted dentist, the benefits paid will be based on the dentist's DG Alliance fee schedule.

Maximum Rollover

For groups with the Maximum Rollover benefit, a portion of the member's unused annual dental maximum can be rolled over into a personal Maximum Rollover Account ("MRA") for future use. Members can save the rolled over dollars for future use, up to a set dollar limit. For covered members, the MRA has no expiration date. Each covered employee and his or her dependents maintain a separate MRA based on their individual claim history.

Some of the maximum rollover benefit plans provide the added incentive to their covered members to utilize an in-network dentist so they can earn additional maximum rollover dollars. Members can use the MRA dollars for future covered treatment.

Standard Plan Limitations

Although Guardian's dental plan limitations and exclusions vary depending on the specific plan design chosen by the employer, here are some of the more common limitations:

- Routine exams/oral evaluations and prophylaxis are limited to once in a six (6) month period or twice per calendar year.
- Adult prophylaxis is covered on patients age twelve (12) or fourteen (14) and older.
- Child prophylaxis is covered on patients under the age of twelve (12) or fourteen (14).
- Either a full mouth series or panoramic radiograph, limited to once in either thirty-six (36) or sixty (60) months.
- Bitewing radiographs are limited to a maximum of four (4) bitewings, or seven to eight (7-8) vertical bitewing radiographs once in either six (6) or twelve (12) months.
- Fluoride is limited to once in six (6) months or twice per calendar year, covered on children up to age 19 or children and adults.
- Sealants are covered on dependents under age sixteen (16), on permanent, unrestored molar teeth, once in a thirty-six (36) month period.
- General anesthesia is covered when done in conjunction with either a surgical procedure or three or more simple extractions, done on the same day.
- The replacement of crowns, bridges, dentures, inlays/onlays, laminate veneers, and post and cores are limited to either five (5) or ten (10) years.
- Lab fees are considered inclusive of the primary procedure.

For information about benefits for a specific patient, please contact our Customer Service Delivery Department at 800-741-7846.

Standard Plan Exclusions

Although Guardian's dental plan limitations and exclusions vary depending on the specific plan design chosen by the employer, here are some of the more common exclusions:

- Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by the plan.
- Any procedure or treatment method, which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Any service or procedure performed on a tooth or teeth with guarded, questionable or poor prognosis from a periodontal, endodontic, or restorative perspective. Considerations for the determination of poor or questionable prognosis include, but are not limited to, advanced bone loss, furcation involvement, tooth mobility, internal/external resorption, root fracture, pulp necrosis and/or a periapical lesion that does not respond to nonsurgical root canal treatment or subsequent surgical intervention, significant loss of tooth structure, poor crown/root ratio and iatrogenic compromising factors.
- Any service or procedure intended solely for the purpose of: (1)Treating or diagnosing disturbances of the temporomandibular joint (unless required by state law), (2) Alteration of vertical dimension or the restoration or maintenance of occlusion, (3) Treating of a condition necessitated by attrition or abrasion, (4) Splinting or stabilizing teeth for periodontal reasons, (5) Treating cervical and/or root sensitivity (6) Cosmetics (including the characterization and personalization of a dental prosthesis).

For information about benefits for a specific patient, please contact our Customer Service Delivery Department at 800-541-7846.

The dentist may bill his/her usual fee for excluded services unless the service is listed on the dentist's fee schedule or considered inclusive of the most comprehensive, related procedure.

Other Benefit Guidelines

Replacement of Crowns, Fixed Bridges, Dentures and Other Dental Services

The replacement of a crown, fixed bridge or denture is not covered within five (5) or ten (10) years, based on the replacement limitations of the plan, utilizing the original placement date. You may verify the age limitations for these procedures by calling our Customer Service Delivery Department at 800-541-7846.

Replacement of Clinically Defective Restorations

Contracted dentists are expected to replace, or retreat services rendered in their office at no additional charge to the patient, if those services are found to be clinically defective due to inadequate technical quality. Guardian will not provide any additional compensation in such circumstances.

Temporary Appliances

Temporary appliances, temporary bridges and temporary crowns are considered part of the permanent procedure. The contracted dentist may only bill the fee schedule amount for the final/permanent appliance, bridge or crown.

Missing Tooth Exclusion

A member may have one or more congenitally missing teeth or have lost one or more teeth before he/she became a member of the plan. Guardian 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 member became insured under the Guardian plan. These contractual guidelines do not apply to an existing restoration or appliance.

VIII. ORTHODONTIC TREATMENT

Many Guardian plans have orthodontic coverage. If a plan does not have orthodontic coverage, the member is still eligible to receive orthodontic treatment at the amount specified on the orthodontic fee schedule, except in those states that prohibit the insurer from requiring that the dentist accept the fee schedule for a service that is not covered under the member's plan. (see Non-Covered Services in section XIII of this Manual).

For all orthodontic treatment, the following information must be submitted to Guardian:

- Total orthodontic treatment fee
- Total estimated number of months of treatment
- Placement date of appliance(s)
- Total fee for orthodontic retainers

Orthodontic Treatment Included in the Fee Schedule

- Treatment plan and records, including initial, interim and final records.
- Limited orthodontic treatment, including fabrication and insertion of any and all fixed appliances and periodic visits.
- Interceptive orthodontic treatment, including fabrication and insertion of any and all fixed appliances and periodic visits.
- Comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances and periodic visits.
- Orthodontic retention, including any and all fixed or removable appliances and related visits.
- Comprehensive orthodontic treatment beyond twenty-four (24) months, not exceeding thirty-six (36) months.

- If a member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the plan provides its 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 contracted orthodontic specialist's usual fees.

Orthodontic Treatment NOT Included in the Fee Schedule

The dentist can bill his or her usual fee for the following:

- The orthodontic benefit considered reflects the benefits available for standard orthodontic appliances. Any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material, including clear aligners or lingual brackets are not covered. These types of appliances are considered optional and/or cosmetic and any additional cost in material may be charged directly to the patient.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- The replacement or repair of orthodontic retainers.
- The replacement or repair of an orthodontic appliance.

The following services are usually covered under the dental plan, even in the absence of an orthodontic benefit provision. The contracted dentist can only bill the fee schedule amount for the following:

- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits.
- Extractions performed solely to facilitate orthodontic treatment.

Orthodontic Treatment in Progress – Benefit Calculation

When a contracted dentist starts orthodontic treatment before the member is eligible for orthodontic benefits under the Guardian plan, the member may be responsible for the fees as originally agreed upon.

If a patient started orthodontic treatment prior to being insured with Guardian, we will pro-rate the orthodontic treatment and fees to determine Guardian's liability. The total treatment fee, the estimated treatment length and the type of orthodontic coverage selected by the plan holder, determines orthodontic benefits. Using the treatment plan, Guardian calculates the total benefit we will pay. Guardian divides this into equal payments, which are spread out over the shorter of two (2) years or the proposed length of treatment. Orthodontic fees incurred prior to the effective date will be excluded.

An example of this is explained below:

- Banding appliance placed 05-01-2018
  The group/member became effective with Guardian on 01-01-2019
  The treatment fee is $3,600.00
  The treatment length is 24 months
  The lifetime orthodontic maximum is $1,000.00

$3,600.00 divided by 24 months equals a $150.00 per month fee, 8 months of treatment are prior to the effective date, 8 months @ $150.00 per month equals $1,200.00 to be excluded. Guardian will consider $2,400.00 for 16 months.

Guardian then applies the dental plan provisions relating to orthodontic coverage (e.g. 50% co-insurance up to the lifetime maximum). The patient/member is responsible for the orthodontic fees that are in excess of the lifetime maximum, up to the dentist's contracted fee schedule amount.

When a group transfers to Guardian from another carrier, Guardian reduces the amount that we pay by the amount paid by the prior carrier. (In the case of a PPD/DHMO plan, the prior carrier may have contracted with dentists to provide a reduced charge. Since the carrier pays no actual benefit, there is no paid amount to apply to our remaining maximum.)

If a prior carrier previously paid $600.00 towards the $1,000.00 lifetime orthodontic benefit, then the maximum that Guardian will pay is $400.00 or the total considered amount at the orthodontic co-insurance percent, whichever is less. In the above example, Guardian would pay a maximum of $400.00 over the remaining treatment length.

Patients Changing Dentists During Orthodontic Treatment

If a covered member transfers from a non-contracted dentist to a contracted dentist, after orthodontic treatment has begun, the contracted dentist should submit a pro-rated amount for the remaining treatment based upon the contracted dentist's fee schedule.

For orthodontic treatment, the following information must be submitted:

- Total orthodontic treatment fee
- Total estimated number of months of treatment
- Placement date of appliance(s)
- Total fee for orthodontic retainer(s)

IX: SPECIALTY REFERRALS

The DentalGuard Plan does not require written approval for specialist referrals from Guardian before selecting a specialist. The member may choose any specialist. By selecting a DentalGuard Preferred specialist the patient will have less out-of-pocket expense. A DentalGuard Preferred specialist can be selected from Guardian's Website (www.GuardianAnytime.com) or by calling the Network Services Department (800-890-4774).

Referring a Patient to Another Dentist or Specialist

If a patient needs to be referred to another dentist for treatment, the patient will have less out-of-pocket expenses if referred to another DentalGuard Preferred dentist.

Finding a Contracted Specialist

The nearest contracted specialist can be located by using Guardian's Website (www.GuardianAnytime.com) or by calling the Network Services Department (800-890-4774). The patient should be informed if they are referred to a non-contracted dentist. It is ultimately the patient's responsibility to verify that the referral is to a contracted dentist.

Overall Patient Care

- Overall patient care should meet professionally recognized standards of practice.

X. GLOSSARY

Active Orthodontics:	Any appliance, fixed or removable braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.
Anterior Teeth:	The incisor and cuspid teeth. The teeth located in front of the bicuspids (or pre-molars).
Contracted Dentist:	A dentist or dental care facility that is under contract with Guardian, its subsidiaries or a third party with whom Guardian contracts.
Covered Dental Specialty:	Any group of procedures that fall under one of the following categories, whether performed by a specialist dentist or general dentist: restorative/prosthodontic services, endodontic services, periodontic services, oral surgery, and pediatric dentistry.
Covered Individual:	An individual who is actively at work on a full-time basis while covered and has met all applicable waiting periods.
Dentist:	Any dental or medical practitioner Guardian is required by law to recognize who, (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this plan.
Eligibility Date:	The earliest date on which the employee is eligible for coverage. For dependent coverage it is the earliest date on which, (a) the employee has initial dependents; and (b) they are eligible for dependent coverage.
Eligible Dependent:	The legal spouse and dependent children who are within the plan's age limits or an unmarried child with a mental or physical handicap or developmental disability, who cannot support him or herself.
Emergency Treatment:	Bona fide emergency services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth and are covered under the plan.
Employee:	A person who works for the employer at the employer's place of business, and whose income is reported for tax purposes using a W-2 form.

Injury:	All damage to a member's mouth due to an accident while a member is insured under the plan, and all complications arising from that damage. The term injury does not include damage to teeth, appliances or dental prosthesis that results solely from chewing or biting food or other substances.
Member:	An employee or any of his or her covered dependents.
Non-Contracted Dentist:	A dentist or dental care facility that is not under contract with Guardian, its subsidiaries or a third party with whom Guardian contracts.
Orthodontic Treatment:	The movement of one or more teeth using active appliances. It includes: (a) treatment plan and records, including initial, interim and final records, (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment or comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; and (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. Some plans do not pay for orthodontic treatment.
Plan:	Guardian group plan purchased by the employer.
Posterior Teeth:	The bicuspid (pre-molars) and molar teeth. The teeth located behind the cuspids are considered posterior.
Prior Plan:	The immediate prior plan/policy of group dental coverage replaced by this plan. This plan must start immediately after the prior dental coverage ends.
Proof of Claim/Loss:	Dental radiographs, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed dental treatment.
Select Network:	The name of the network that is available to payers other than Guardian. Examples would be a third-party administrator (TPA) who processes claims for large self-insured or self-administered employer groups or unions and other insurance carriers. **NOTE:** Plans accessing the Select Network **are not** Guardian members or Guardian administered plans.

XI. STATE REQUIRED NOTIFICATIONS

Conformity with State Statues

If any provision of this Manual conflicts with any applicable state law, the provision will be deemed to conform to the requirements of the law.

XII. CORPORATE POLICIES AND PROCEDURES

Guardian Logo Usage

A dentist who wishes to utilize the Guardian logo for marketing materials must receive permission allowing them this right. Please call 866-229-1970 for more information.

XIII. STATE SPECIFIC INFORMATION

See Appendices

Appendix A

States with Non-Covered Service Regulations

1. Alabama
2. Alaska
3. Arizona
4. Arkansas
5. California
6. Colorado
7. Connecticut
8. Florida
9. Georgia
10. Idaho
11. Illinois
12. **Iowa**
13. Kansas
14. Kentucky
15. **Louisiana**
16. **Maryland**
17. Minnesota
18. Mississippi
19. **Missouri**
20. Montana
21. Nebraska
22. Nevada
23. New Jersey
24. New Mexico
25. North Carolina
26. **North Dakota**
27. Oklahoma
28. Oregon
29. **Pennsylvania**
30. **Rhode Island**
31. **South Dakota**
32. Tennessee
33. Texas
34. Utah
35. Virginia
36. Washington
37. West Virginia
38. Wisconsin
39. **Wyoming**

The bolded state's non-covered service legislation defines non-covered services as procedures that are never covered under the plan and services that are not reimbursed, unless the reimbursement is applied to the patient's deductible.

Louisiana – Non-covered services are defined as procedures that are never covered under the dental plan and services that are not reimbursed, unless the reimbursement was applied to an annual maximum, coinsurance, deductible, frequency limitation or waiting period.

North Dakota – Non-covered services are defined as procedures that are never covered under the dental plan and services that are not reimbursed, unless the reimbursement was applied to an annual or lifetime maximum, coinsurance, copayment, deductible, frequency limitation or waiting period.

Pennsylvania – Non-covered services are defined as procedures that are never covered under the dental plan and services that are not reimbursed, unless the reimbursement was applied to an alternative benefit payment, annual or lifetime maximum, copayment, coinsurances, deductible, frequency limitation or waiting period.

All other states define non-covered services as procedures that are never covered under the dental plan.

Appendix B

STATE SPECIFIC INFORMATION

CALIFORNIA

Addendum

The Dentist Agreement and/or its attachments, including, but not limited to Chosen Networks Addendum, Fee Schedule(s), Rules, Guidelines, and Policies and Procedures concerning dental provider contracting or coverage of, or payment for dental services, may be amended by Guardian at any time upon forty-five (45) business days prior written notice to the dentist. If the amendment is not acceptable to the dentist, he or she must reject the amendment by providing written notice to Guardian within the forty-five (45) business day period. If notice of rejection is not received by Guardian, it will be understood that the dentist has accepted the amendment. For additional information regarding amendments, please refer to the Dentist Agreement.

Provider Notice of Changes

As required by California regulations, a contracted dentist has the right to annually request and receive within sixty (60) days of receipt of a request, copies of the current contract, all such policies which are applicable to the dentist or to particular health care services identified by the dentist and a summary of all the changes made since the contract was issued or last renewed. To obtain this information, please contact Network Services at the address or telephone number (800-890-4774) identified in the Quick Reference Section, at the front of this manual.

Appendix B

STATE SPECIFIC INFORMATION

COLORADO

Preventive

When the same dentist performs the following services on the same day, the less inclusive service will be considered part of the more comprehensive service.

Two exams* -
the less comprehensive exam is inclusive of the more comprehensive exam.

Exam and **Consultation** –
the exam is inclusive of the consultation.

Exam and **palliative treatment** –
the exam is inclusive of the palliative treatment.

Intraoral periapical, **occlusal** or **extraoral film** and a **complete series** –
the intraoral periapical, occlusal or extraoral film is inclusive of the complete series.

Intraoral periapical, **occlusal** or **extraoral film** and a **root canal** or **pulpal therapy**
the intraoral periapical, occlusal or extraoral film is inclusive of the root canal or pulpal therapy.

Bitewing films and a **complete series** –
the bitewing films are inclusive of the complete series.

Prophylaxis and **osseous surgery** –
the prophylaxis is inclusive of the osseous surgery.

Unilateral space maintainer and **bilateral space maintainer** in the same arch -
the unilateral space maintainer is inclusive of the bilateral space maintainer.

Space maintainer and **fixed pediatric partial denture** in the same arch –
the space maintainer is inclusive of the fixed pediatric partial denture.

When the same dentist performs the following services within a certain time frame, the less inclusive service will be considered part of the more comprehensive service.

If an **intraoral periapical**, **occlusal** or **extraoral film** is performed within 14 days of a **root canal** or **pulpal therapy** -
the intraoral periapical, occlusal or extraoral film is inclusive of the root canal or pulpal therapy.

*Exams are listed in the order of least comprehensive to most comprehensive: Periodic oral evaluation, Limited oral evaluation – problem focused, Comprehensive oral evaluation, Re-evaluation – limited, problem focused, Comprehensive periodontal evaluation and Detailed and extensive oral evaluation.

Restorative

When more than one restorative service is performed on the same tooth, on the same day, by the same dentist, the less inclusive restorative service will be considered part of the more comprehensive restorative service.

Consultation on slides prepared elsewhere or **consultation, including preparation of slides from biopsy material supplied by referring source** and an **exam** –
the consultation on slides prepared elsewhere or consultation, including preparation of slides from biopsy material supplied by referring source is inclusive of the exam.

Amalgam or **resin-based composite filling** and all **adhesives, bonding agents, liners** and/or **bases** –
the amalgam or resin-based composite filling includes all adhesives, bonding agents, liners and bases.

Amalgam, **resin-based composite filling** or **composite crown** and a **core buildup** or a **cast post and core** –
the amalgam, resin-based composite filling or composite crown is inclusive of the core buildup or cast post and core.

Resin-based composite filling and a **resin-based composite crown** –
the resin-based composite filling is inclusive of the resin-based composite crown.

Amalgam or **resin-based composite filling** and an **inlay** or **onlay** –
the amalgam or resin-based composite filling is inclusive of the inlay or onlay.

Inlay and an **abutment**, **crown** or **onlay** –
the inlay is inclusive of the abutment, crown or onlay.

Recementation of a crown, inlay, onlay, veneer or bridge and a **crown**, **inlay**, **onlay**, **veneer** or **bridge-**
the recementation is inclusive of the appliance or dental prosthesis.

Recementation of cast or prefabricated post & core and a **cast post & core** or **prefabricated post & core** –
the recementation is inclusive of the cast or prefabricated post & core.

Sedative filling and a **pulp cap** or **pulpotomy** –
the sedative filling is inclusive of the pulp cap or pulpotomy.

Sedative filling and an **amalgam** or **resin based composite filling** –
the sedative filling is inclusive of the filling.

Core buildup and a **cast post and core** or **prefabricated post and core** –
the core buildup is inclusive of the cast post and core or prefabricated post and core.

Prefabricated post and core and a **cast post and core** –
the prefabricated post and core is inclusive of the cast post and core.

Post removal and a **root canal retreatment** –
the post removal in inclusive of the root canal retreatment.

Veneer and a **crown**, **abutment** or **pontic** –
the veneer is inclusive of the crown, abutment or pontic.

When the same dentist performs the following services within a certain time frame, on the same tooth, the less inclusive service will be considered part of the more comprehensive service

Core buildup performed within 30 days of a **cast post and core** or **prefabricated post and core**
- the core buildup is inclusive of the cast post and core or prefabricated post and core.

Pin retention performed within 60 days of a **core buildup -**
the pin retention is inclusive of the core buildup.

Pin retention performed within 60 days of an **abutment**, **crown**, **resin-based composite crown**, **stainless steel crown, prefabricated resin crown** or **prefabricated esthetic coated stainless steel crown (primary tooth) -**
the pin retention is inclusive of the abutment, crown, resin-based composite crown, stainless steel crown or prefabricated resin crown, prefabricated esthetic coated stainless steel crown (primary tooth).

Abutment, **crown**, **inlay** or **onlay** performed less than 24 months after a **resin-based composite crown**, **stainless steel crown**, **prefabricated resin crown, prefabricated esthetic coated stainless steel crown (primary tooth)** or **temporary crown (fractured tooth) -**
the amount paid for the resin-based composite crown, stainless steel crown, prefabricated resin crown, prefabricated esthetic coated stainless steel crown (primary tooth) or temporary crown (fractured tooth) is deducted from the amount payable for the abutment, crown, inlay or onlay.

*Rest.oration consists of: Amalgams, Composites, Prefabricated resin and Stainless-steel crowns, Inlays, Onlays, Veneers, Crowns, and Abutments

Endodontics

When more than one endodontic service is performed on the same tooth, on the same day, by the same dentist, the less inclusive endodontic service will be considered part of the more comprehensive endodontic service.

Pulp cap (direct or indirect) and a **pulpotomy**, **pulpal debridement**, **root canal therapy**, **internal root repair** or **apexification** –
the pulp cap is inclusive of the pulpotomy, pulpal debridement, root canal therapy, internal root repair or apexification.

Pulpotomy and **root canal therapy**, **apexification**, **pulpal therapy** or **treatment of root canal obstruction** –
the pulpotomy is inclusive of the root canal therapy, apexification, pulpal therapy or treatment of root canal obstruction.

Pulpal debridement and **pulpal therapy** or **root canal therapy** –
the pulpal debridement is inclusive of the pulpal therapy or root canal therapy.

Root canal therapy and **apexification** or **incomplete endodontic therapy** –
the root canal therapy is inclusive of the apexification or incomplete endodontic therapy.

Treatment of root canal obstruction and **incomplete endodontic therapy** or **apicoectomy** –
the root canal obstruction is inclusive of the incomplete endodontic therapy or apicoectomy.

Retreatment of root canal therapy and **root canal therapy** –
the retreatment of root canal therapy is inclusive of root canal therapy.

Retreatment of root canal therapy and **incomplete endodontic therapy** or **apexification** –
the retreatment of root canal therapy is inclusive of the incomplete endodontic therapy or apexification.

Root amputation and an **apicoectomy** –
the root amputation is inclusive of the apicoectomy.

Surgical and non-surgical procedure for isolation of tooth with rubber dam and **any procedure** –
the rubber dam is inclusive of the more comprehensive procedure.

Canal preparation and **prefabricated post and core** or **core buildup** –
the canal preparation is inclusive of the prefabricated post and core or core buildup.

When the same dentist performs the following services within a certain time frame, on the same tooth, the less inclusive service will be considered part of the more comprehensive service.

Pulp cap (direct or indirect) performed within 14 days of **root canal therapy** or **apexification** –
the amount paid for the pulp cap is deducted from the amount payable for the root canal therapy of apexification.

Pulpotomy performed within 14 days of **pulpal therapy**, **root canal therapy** or **apexification** –
the amount paid for the pulpotomy is deducted from the amount payable for pulpal therapy, root canal therapy or apexification.

Retreatment of root canal therapy performed within 90 days of **root canal therapy** –
the retreatment of root canal therapy is inclusive of the root canal therapy.

Root amputation performed within 14 days of an **apicoectomy** –
the root amputation is inclusive of the apicoectomy.

Periodontics

When the same dentist performs more than one periodontal service in the same area of the mouth, on the same day, the less inclusive periodontal service, will be considered part of the more comprehensive periodontal service.

Gingivectomy/gingivoplasty or **crown lengthening** and an **abutment**, **crown**, **resin-based composite crown**, **stainless steel crown**, **prefabricated resin crown** or **temporary crown (fractured tooth)** on the same tooth –

the gingivectomy/gingivoplasty or crown lengthening is inclusive of the abutment, crown, resin-based composite crown, stainless steel crown, prefabricated resin crown or temporary crown (fractured tooth).

Gingivectomy/gingivoplasty and **gingival flap procedure**, **osseous surgery**, or **implant placement** in the same quadrant –

the gingivectomy/gingivoplasty is inclusive of the gingival flap procedure, osseous surgery or implant placement.

Gingivectomy/gingivoplasty and **distal proximal wedge procedure**, **pedicle soft tissue graft**, **free soft tissue graft** or **subepithelial connective tissue graft** in the same area of the mouth –

the gingivectomy/gingivoplasty is inclusive of the distal proximal wedge procedure, pedicle soft tissue graft, free soft tissue graft or subepithelial connective tissue graft.

Gingival flap procedure and **osseous surgery** in the same area of the mouth –

the gingival flap procedure is inclusive of the osseous surgery.

Gingival flap procedure and **implant** in the same area of the mouth –

the gingival flap procedure is inclusive of the implant.

Apically positioned flap with an **anterior extraction** in the same area of the mouth –

the apically positioned flap is part of the extraction.

Apically positioned flap with an **implant**, **surgical access of an unerupted tooth**, or **surgical exposure of impacted or unerupted tooth** in the same area of the mouth –

the apically positioned flap is inclusive of the implant, surgical access of unerupted tooth or surgical exposure of impacted or unerupted tooth.

Apically positioned flap and **gingivectomy/gingivoplasty** or **osseous surgery** in the same area of the mouth –

the apically positioned flap is inclusive of the gingivectomy/gingivoplasty or osseous surgery.

Crown lengthening and **osseous surgery**, **bone replacement graft**, or **guided tissue regeneration** in the same area of the mouth –

the crown lengthening is inclusive of the osseous surgery, bone replacement graft or guided tissue regeneration.

Guided tissue regeneration and **surgical revision procedure** in the same area of the mouth –

the guided tissue regeneration is inclusive of the surgical revision procedure.

Bone replacement graft and **surgical revision procedure** in the same area of the mouth –

the bone replacement graft is inclusive of the surgical revision procedure.

Surgical revision procedure and **gingivectomy/gingivoplasty**, **gingival flap procedure**, **osseous surgery**, **bone replacement graft**, **distal proximal wedge** or **tissue graft** in the same area of the mouth –

the surgical revision procedure is inclusive of the gingivectomy/gingivoplasty, gingival flap procedure, osseous surgery, bone replacement graft, distal proximal wedge or tissue graft.

Surgical revision procedure and **apically positioned flap**, **crown lengthening**, **surgical access of an unerupted tooth**, **surgical exposure of impacted or unerupted tooth to aid in eruption**, **alveoloplasty** or **vestibuloplasty** in the same area of the mouth –

the surgical revision procedure is inclusive of the apically positioned flap, crown lengthening, surgical access of an unerupted tooth, surgical exposure of impacted or unerupted tooth to aid in eruption, alveoloplasty or vestibuloplasty.

Multiple soft tissue grafts* in the same area of the mouth –

the less inclusive soft tissue graft will be inclusive of the more comprehensive soft tissue graft

Distal proximal wedge procedure and **osseous surgery** or an **implant** in the same area of the mouth –

the distal proximal wedge procedure is inclusive of the osseous surgery or implant.

Soft tissue allograft and a **soft tissue graft** in the same area of the mouth –

the soft tissue allograft is inclusive of the soft tissue graft.

Scaling and root planning and **osseous surgery** in the same quadrant –

the scaling and root planning is inclusive of osseous surgery.

Periodontal maintenance and **osseous surgery** – the periodontal maintenance is inclusive of osseous surgery.

When the same dentist performs the following services within a certain time frame, in the same area of the mouth, the less inclusive service will be considered part of the more comprehensive service.

Gingivectomy/gingivoplasty performed within 30 days of an **implant** in the same area of the mouth –

the gingivectomy/gingivoplasty is inclusive of the implant.

Surgical revision procedure performed within 30 days of **gingivectomy/gingivoplasty**, **gingival flap procedure**, **osseous surgery**, **bone replacement graft**, or a **soft tissue graft** in the same area of the mouth –

surgical revision procedure is inclusive of the gingivectomy/gingivoplasty, gingival flap procedure, osseous surgery, bone replacement graft, or a soft tissue graft.

Surgical revision procedure performed within 30 days of **apically positioned flap**, **surgical access of an unerupted tooth**, **surgical exposure of impacted or unerupted tooth to aid eruption**, **alveoloplasty** or **vestibuloplasty** in the same area of the mouth –

the surgical revision procedure is inclusive of the apically positioned flap, surgical access of an unerupted tooth, surgical exposure of impacted or unerupted tooth to aid eruption, alveoloplasty or vestibuloplasty.

Surgical revision procedure performed within 12 months of **crown lengthening** or **gingivectomy/gingivoplasty** in the same area of the mouth –
the surgical revision procedure is inclusive of the crown lengthening or gingivectomy/gingivoplasty.

*Soft tissue grafts are listed in the order of least comprehensive to the most comprehensive: Pedicle soft tissue graft, Free soft tissue graft procedure (including donor site surgery) and Subepithelial connective tissue graft procedures.

Prosthodontics (removable)

When the same dentist performs more than one prosthodontic service in the same arch, on the same day, the less inclusive prosthodontic service will be considered with the more comprehensive prosthodontic service.

Adjustment of denture and a **complete denture**, **partial denture** or **interim denture** –
the adjustment is inclusive of the complete denture, partial denture or interim denture.

Adjustment of denture and a **reline** –
the adjustment is inclusive of the reline.

Adjustment or **repair of denture** and **replacement of all teeth and acrylic on cast metal framework** –
adjustment or repair of denture is inclusive of the replacement of all teeth and acrylic on cast metal framework.

Replace broken teeth and the **replacement of all teeth and acrylic on cast metal framework** –
the replacement of broken teeth is inclusive of the replacement of all teeth and acrylic on cast metal framework.

Add tooth or clasp to existing partial denture and **interim partial denture** –
the adding of a tooth or clasp to existing partial denture is inclusive of the interim partial denture.

Replacement of all teeth and acrylic on cast metal framework and a **complete**, **partial** or **interim denture** –
the replacement of all teeth and acrylic on cast metal framework is inclusive of the complete, partial or interim denture.

Denture rebase or reline and a **complete**, **partial** or **interim denture** –
the denture rebase or reline is inclusive of the complete, partial or interim denture.

Denture reline and a **denture rebase** –
the denture reline is inclusive of the denture rebase.

Interim complete or partial denture and a **complete or partial denture** –
the interim denture is inclusive of the complete or partial denture.

Tissue conditioning and a **complete**, **partial** or **interim denture** –
the tissue conditioning is inclusive of the complete, partial or interim denture.

When the same dentist performs the following services within a certain time frame, in the same area of the mouth, the less inclusive service will be considered part of the more comprehensive service.

Adjustment of a denture performed within 12 months of a **complete denture**, **partial denture** or **interim denture** –
the adjustment is inclusive of the complete, partial or interim denture.

Adjustment of denture and a **reline** in the last 6 months –
the adjustment is inclusive of the reline.

Adjustment or repair of a denture and the **replacement of all teeth and acrylic on cast metal framework** in the last 6 months –
the adjustment is inclusive of the replacement of all teeth and acrylic on cast metal framework.

Replace broken teeth and the **replacement of all teeth and acrylic on cast metal framework** in the last 6 months –
the replacement of broken teeth is inclusive of the replacement of all teeth and acrylic on cast metal framework.

Replacement of all teeth and acrylic on cast metal framework and a **complete**, **partial** or **interim denture** in the last 6 months –
the replacement of all teeth and acrylic on cast metal framework is inclusive of the complete, partial or interim denture.

Denture rebase or reline and a **complete**, **partial** or **interim denture** in the past 12 months –
the denture rebase or reline is inclusive of the complete, partial or interim denture.

Interim denture and a **denture** in the past 12 months –
the interim denture is inclusive of the denture.

Tissue conditioning and a **complete**, **partial** or **interim denture** in the past 12 months –
the tissue conditioning is inclusive of the complete, partial or interim denture.

Implant Services

Implants may be covered under a Guardian plan, if the plan holder elects implant coverage, the following bundling rule will apply:

Repair implant abutment and **implant placement** in the same area of the mouth –
repair implant is inclusive of the implant placement.

Prosthodontics (fixed)

When the same dentist performs more than one prosthodontic service on the same tooth, on the same day, the less inclusive prosthodontic service will be considered inclusive of the more comprehensive prosthodontic service.

Fixed partial denture retainer inlay or onlay and an **abutment** or **crown** –
the fixed partial denture retainer inlay or onlay is inclusive of the abutment or crown.

Recement bridge and an **abutment** –
the recementation of the bridge is inclusive of the abutment.

Oral and Maxillofacial Surgery

When the same dentist performs more than one oral surgical service in the same area of the mouth/tooth, on the same day, the less inclusive service will be considered with the more comprehensive service.

Extraction or removal of residual root and a **hemisection** or **intentional reimplantation** on the same tooth –
the extraction or removal of residual root is inclusive of the hemisection or intentional reimplantation.

Surgical access of an unerupted tooth and an **extraction** on the same tooth –
the surgical access of an unerupted tooth is inclusive of the extraction.

Mobilization of erupted or malpositioned tooth to aid eruption and an **extraction** on the same tooth –
the mobilization of erupted or malpositioned tooth to aid eruption is inclusive of the extraction.

Surgical removal of residual tooth roots and an **extraction** on the same tooth –
the surgical removal of residual tooth roots is inclusive of the extraction.

Placement of device to facilitate eruption of impacted tooth and an **extraction** on the same tooth –
the placement of device to facilitate eruption of impacted tooth is inclusive of the extraction.

Biopsy of oral tissue and an **apicoectomy** in the same area of the mouth –
the biopsy is inclusive of the apicoectomy or root canal obstruction.

Brush biopsy and an **extraction** in the same area of the mouth –
the brush biopsy is inclusive of the extraction.

Alveoloplasty and an **extraction(s)** in the same area of the mouth –
the alveoloplasty is inclusive of the extraction(s).

Incision and drainage of an abscess and **root canal therapy**, **apexification**, **apicoectomy** or **treatment of root canal obstruction** in the same area of the mouth –
the incision and drainage is inclusive of the root canal therapy, apexification, apicoectomy or treatment of root canal obstruction. This can be appealed if the incision and drainage of an abscess is unrelated to the root canal therapy, apexification, apicoectomy or treatment of root canal obstruction.

Frenulectomy (frenectomy or frenotomy) and a **tissue graft** in the same area of the mouth –
the frenulectomy (frenectomy or frenotomy) is inclusive of the tissue graft.

Sutures and **any surgical procedure** –
the sutures are inclusive of the surgical procedure.

Adjunctive General Services

Local anesthesia and any **restoration**, **endodontic**, **periodontic**, **prosthodontic (removable or fixed)**, **implant, simple extraction** or **surgical extraction procedure** –
the local anesthesia is inclusive of the restorative, endodontic, periodontic, prosthodontic (removable or fixed), implant, simple extraction or surgical extraction procedure.

Anesthesia* – the less inclusive form of anesthesia will be inclusive of the more comprehensive form of anesthesia.

Office visit and **exam**, **consultation** or **palliative treatment** –
the office visit is inclusive of the exam, consultation or palliative treatment.

Occlusal adjustment and any **restoration*** –
the occlusal adjustment is inclusive of the restoration.

Odontoplasty and any **restoration*** -
the odontoplasty is inclusive of the restoration.

When the same dentist performs the following services within a certain time frame, in the same area of the mouth, the less inclusive service will be considered part of the more comprehensive service

Sutures and an **extraction(s)** or **any oral surgical** service in the past 30 days –
the sutures are inclusive of the extraction(s) or oral surgical service.

Treatment of complications (post-surgical) and **any oral surgical procedure** within the past 30 days-
the treatment of complications (post-surgical) is inclusive of the oral surgical procedure.

*Restoration consists of: Amalgams, Composites, Prefabricated resin and Stainless-steel crowns, Inlays, Onlays, Veneers, Crowns and Abutments.

*Anesthesia is listed in the order of the least comprehensive to the most comprehensive: Local anesthesia, Regional block anesthesia, Trigeminal division block anesthesia, Non-intravenous conscious sedation, Intravenous sedation and General anesthesia.

COLORADO SUMMARY DISCLOSURE FORM

THIS SUMMARY DISCLOSURE FORM IS FOR INFORMATIONAL PURPOSES ONLY AND IS NOT A TERM OR CONDITION OF THE DENTIST AGREEMENT

Category of Coverage, Compensation and Payment

DentalGuard Preferred Dentists agree to provide professional dental services through individual and group contracts with employee groups, unions, corporations, insurance companies and other payors and to make such dental services available to eligible employees or members of such groups and their covered dependents.

The DentalGuard Preferred Dentist must submit a dental claim to receive reimbursement. The Member's Identification Card will provide the name and address for the processing of the claims. All benefit payments will be sent directly to the DentalGuard Preferred Dentist. An explanation of benefits will be sent to the DentalGuard Preferred Dentist and Member.

DentalGuard Preferred Dentists are compensated on a fee-for-service basis and receive a Fee Schedule, Exhibit A of the Participating Dentist Agreement, which represents the maximum allowable charge payable by Guardian, the Member and/or another payer. For a description of Guardian's Fee Schedule methodology, please refer to the applicable section in the DentalGuard Preferred Network Dentist Manual.

DentalGuard Preferred Dentists agree to accept as payment in full, the lesser of the amount charged by the Dentist or the Fee Schedule amount for listed services rendered to Covered Members. DentalGuard Preferred Dentists shall look solely to the applicable payer for compensation and shall not seek compensation from Covered Members, except for co-payments, deductibles or charges for services not covered under the dental plan. For additional information regarding Dental Coverage, please refer to the relevant section in the DentalGuard Preferred Network Dentist Manual.

DentalGuard Preferred Dentists may refer to the DentalGuard Preferred Network Dentist Manual to determine the effect of edits, if any, upon their payment with respect to services rendered to Covered Members.

Utilization Review and Utilization Management

Utilization Review: Guardian does not require Members to obtain pre-authorization for dental services and treatment. It is recommended for high cost procedures. We will base benefits on the least expensive service that is within the range of professionally accepted and appropriate standards of dental practice. Any decision to pay benefits for a less expensive service is made by a dentist consultant, who evaluates all the clinical information and determines if the proposed procedure(s) are consistent with the terms of the patient's dental contract. If insufficient information is provided to make a clinical determination, the claims coordinator will make a good faith attempt to obtain the required information from the member or treating dentist. The member has the right to appeal the reduction or denial of dental benefits. The member or treating dentist may provide additional information, including x-rays, narrative, treatment records and/or photographs. Guardian will reevaluate the new information and, if indicated, have a dentist consultant review the claim. The member and treating dentist are notified of the decision in writing.

Utilization Management: The Utilization Management Process allows us to identify the most appropriate claims for professional review. Utilizing data compiled from multiple insurance carriers, we can provide a more targeted and focused review of claims. New review processes are loaded as necessity is determined.

Duration of Contract, Termination of Contract

The term of the Participating Dentist Agreement is one (1) year and will automatically renew for subsequent twelve (12) month periods, unless earlier terminated by the dentist or Guardian in accordance with the terms and conditions of the Participating Dentist Agreement. Terminating the Participating Dentist Agreement with Guardian requires written legal notice, which should be sent to Dental Network Services, P.O. Box 981574, El Paso, TX 79998-1574. The Dentist shall continue to provide dental services to Covered Members for sixty (60) days from the date notification of the termination of the Participating Dentist Agreement is received by Guardian. For additional information regarding the termination of a Participating Dentist Agreement, please refer to the Participating Dentist Agreement and Exhibit B, State Specific Provisions.

The Participating Dentist Agreement also provides information regarding the reasons why Guardian might terminate the Participating Dentist Agreement. Depending on the reason for termination, Guardian may report the termination to the Colorado State Board of Dental Examiners, the National Practitioner Data Bank (NPDB), and/or the Healthcare Integrity and Protection Data Bank (HIPDB).

Dispute Resolutions

Complaints received by Guardian concerning dental services rendered by a DentalGuard Preferred Dentist will be resolved in accordance with Guardian's grievance procedures. For additional information regarding Guardian's grievance process, please refer to the DentalGuard Preferred Network Dentist Manual. All disputes, controversies, or claims relating to the performance or interpretation of the Participating Dentist Agreement shall be submitted to a Board of Arbitrators. For additional information regarding Arbitration, please refer to the Participating Dentist Agreement.

Addendum

The Dentist Agreement and/or its attachments, including Exhibit A, Fee Schedule and Exhibit B, State Specific Provisions, may be amended by Guardian at any time upon thirty (30) days prior written notice to the Dentist or earlier if required by law. For additional information regarding Amendments, please refer to the Participating Dentist Agreement.

Appendix B

STATE SPECIFIC INFORMATION

CONNECTICUT

Within five (5) business days of the date a dentist requests termination or is terminated from the DentalGuard Preferred Network, the dentist shall supply Guardian with a list of his/her patients that are covered by a Guardian plan.

In accordance with Connecticut state law, a notification of termination of the dentist's contract will be sent to all members who are patients that have been seen on a regular basis within the prior twelve (12) months.

Section 5.7 of this Agreement shall not require Dentist to indemnify Guardian for any expenses and liabilities on the basis of Guardian's determination of medical necessity or appropriateness of health care services if the information provided by Dentist and used in making the determination was accurate and appropriate at the time the information was given.

Notwithstanding anything to the contrary in the Agreement, Guardian may not require Dentist to accept the Fee Schedule amount as payment in full for non-Covered Services provided to Covered Individuals with individual or group fully insured dental plans issued or renewed on or after January 1, 2012. For purposes of this section "Covered Services" shall mean services that may be fully or partially reimbursable under the applicable Plan, subject to any applicable Plan conditions or limitations. Services that are never covered under the applicable Plan, whether due to an express exclusion, or because they are beyond the scope of the applicable Plan, are considered non-Covered Services to which the Fee Schedule does not apply. Dentist shall not charge more for services or procedures that are not Covered Services than Dentist's usual and customary rate for such services or procedures. Dentist shall post, in a conspicuous place, a notice stating that services or procedures that are not Covered Services under an insurance policy or plan might not be offered at a discounted rate.

Appendix B

STATE SPECIFIC INFORMATION

MAINE

Terminating from the Network

Within ten (10) business days of the date a provider requests to be terminated or is notified of impending termination from the DentalGuard Preferred Network, the dentist shall supply Guardian with a list of his/her patients that are covered by a Guardian plan. In accordance with Maine state law, sixty (60) days preceding the termination date, a notification of termination of the dentist's contract will be sent to all members who are patients that have been seen on a regular basis. Guardian will not disclose any reason for the termination to its members.

Appendix B

STATE SPECIFIC INFORMATION

MARYLAND

Fee Schedules

Fees paid to contracted dentists are set to a level that is competitive yet provides value to members. Fees vary by area depending on cost of living and concentration of dentists and members. To determine the most appropriate fees several factors are considered, including claim volume, sales and provider recruitment goals, dentist charges and the level of fees paid by other carriers. Fees are not provided on an incentive or bonus-based compensation.

Appendix B

STATE SPECIFIC INFORMATION

NORTH CAROLINA

Complaint/Grievance Process

The covered individual's records (which may include, but not be limited to, radiographs, charting, and clinical documentation) should be available for review, upon request, by Guardian or the North Carolina Department of Insurance, Managed Care and Health Benefits Division, as required by 11 NCAC 20.0202 (11)(c). All records and any personal information related to the covered individual will be treated as confidential.

Appendix B

STATE SPECIFIC INFORMATION

OHIO

Electronically Submitted Claims

Ohio revised code §3901.381 requires insurers to electronically pay claims they receive electronically from contracted dentists. All dentists must sign up to receive Electronic Funds Transfer (EFT) payments. Call 866-506-2830 to speak with an Enrollment Representative at “Change Healthcare” (formerly Emdeon) and select Option 1. You may also access “Change Healthcare’s) website directly via www.GuardianAnytime.com to enroll.

Appendix B

STATE SPECIFIC INFORMATION

RHODE ISLAND

Policy and Procedure Input

Provider Input

Dentists may submit written input regarding Guardian's policies including technology; medications; procedures; utilization review criteria; quality criteria; credentialing criteria; and dental care management procedures. All written documentation will be reviewed.

Member Input

Members may submit written input regarding Guardian's procedures and processes regarding the delivery of dental care services. All written documentation will be reviewed.

Appendix B

STATE SPECIFIC INFORMATION

VERMONT

Balance Billing

If the dentist terminates his or her contract with Guardian and the services were performed while the dentist was contracted with Guardian and/or if the plan holder or member terminates coverage with Guardian and the services were performed while the member was insured with Guardian, the dentist is prohibited from balance billing a member more than the fee schedule amount. The fee schedule shall supersede any oral or written agreement regarding fees between a member and a dentist.

Confidentiality

Policies and procedures have been implemented to ensure that all applicable state and federal laws regarding Protected Health Information (PHI) are adhered to and in compliance with the Health Insurance Portability Accountability Act (HIPAA) of 1996 and its related regulations.

Complaint Process

The covered individual's records (which may include, but not be limited to, radiographs, charting, and clinical documentation) should be available for review, upon request, by Guardian or the Vermont Department of Insurance as required by Vermont (Rule 10). All records and any personal information related to the covered individual will be treated as confidential.

Policy and Procedure Input

Providers may submit written input regarding Guardian's Utilization Management (UM) program, dispute resolution process, and Quality Assessment (QA) program. All written documentation will be reviewed.

Terminating from the Network

The DentalGuard Preferred Dentist Agreement may be terminated at any time upon written "legal notice" sent to us return receipt requested. Such termination shall be effective sixty (60) days from the date Guardian receives the letter, in accordance with state regulations.

Within five (5) working days of the date a dentist requests termination or is terminated from the DentalGuard Preferred Network, the dentist shall supply Guardian with a list of his/her patients that are covered by a Guardian plan. In accordance with Vermont state law, notification of termination of the dentist's contract will be sent to all members who are patients that have been seen on a regular basis.

Terminating your Dentist Agreement with Guardian requires a written "legal notice" which should be sent return receipt requested to:

The Guardian Life Insurance Company of America
Dental Network Services
P.O. Box 981574
El Paso TX 79998-1574

Appendix B

STATE SPECIFIC INFORMATION

VIRGINIA

As required by Virginia regulations, a contracted dentist has the right to request, and receive within ten (10) business days of receipt of a request, copies of all such policies which are applicable to the contracted dentist or to particular health care services identified by the dentist. To obtain this information, please contact Network Services at the address or telephone number (800-890-4774) identified in the Quick Reference Section, at the front of this manual.

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