Benefit and Cost Summary

for Dental Maximum Rollover Plan has been prepared for the employees of:

Enhanced Plan

IIABA

In-Network Deductible- $50 (*Waived for Preventive Services)
Out-of-Network Deductible- $50 (*Waived for Preventive Services)

	Percentage Paid	
Services	In-Network	Out-of-Network
Preventive Services*	100%	80%
Emergency Palliative Treatment		
Oral Examination - every six months		
X-Rays - four bitewings every twelve months full mouth series every five years		
Teeth Cleaning - every six months		
Fluoride Treatments for Children - every six months under age 14		
Space Maintainers for Children - under age 16		
Topical Sealants for unrestored molar teeth -one treatment for child(ren) under 16 in a three (3) year period		
Basic Services	90%	80%
Laboratory Test		
Diagnostic Consultation- one per year		
Fillings: Amalgam, Silicate & Acrylic		
Crowns: Stainless Steel		
Repairs of dentures, bridgework, crowns, etc.		
Endodontic Services/Root Canal Therapy		
Periodontal Services		
Oral Surgery- Uncomplicated extractions		
General Anesthesia- surgical procedures only		
Injectable Antibiotics- for treatment of a dental condition only		
Major Services	60%	50%
Bridges Installation-fixed and removable		
Dentures- Full and Partial		
Crowns: Acrylic Metal, Porcelain		
Inlays		
Onlays		
Posts		
Implants		
Orthodontic Services		50%
$1,500 Lifetime Maximum for child(ren) under age 19		
The deductible does not apply to Orthodontic services.		

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Benefit and Cost Summary

- There is a $1,000 annual maximum for Preventive, Basic and Major services combined, subject to the maximum rollover.
- **Maximum Rollover:** With Maximum Rollover, we'll roll over a portion of each member's unused annual maximum, called the Maximum Rollover Amount, into his or her Maximum Rollover Account (MRA). The MRA can be used in future years, if a member reaches the plan's Annual Maximum.

  Even better, if a member uses the services of Preferred Providers exclusively during the benefit year, we'll increase the amount credited to his or her MRA to the In-network Only Maximum Rollover Amount.

  To qualify, a member must submit a claim and not exceed the paid claims Threshold during the benefit year. The employee and each insured dependent maintain separate MRAs based on their own claim activity. Each member's MRA may not exceed the MRA limit.

PLAN ANNUAL MAXIMUM *	THRESHOLD	MAXIMUM ROLLOVER AMOUNT	IN-NETWORK ONLY MAXIMUM ROLLOVER AMOUNT	MAXIMUM ROLLOVER ACCOUNT LIMIT
$1000	$500	$250	$350	$1000

- *Deductible is waived for Preventive services. 3 individual deductibles per family.
- Children are covered up to age 20 or 26 if a full time student.
- Employee/Dependents enrolling outside of the plan eligibility period may be subject to Late Entrant[1] penalties.
- All out of network services are based on usual, reasonable, and customary rates for given area.
- Dental Claims - P. O. Box 2459, Spokane, WA 99210-2459, ph: 1-800-541-7846, fax: 509-468-4590.
- Guardian has contracted with dental providers to provide discounts off services and procedures to Guardian dental plan members. To locate a provider, please reference our On-Line Provider Directory at www.GuardianLife.com.
- Pre-determination Review - Guardian will gladly assist you and your dentist by determining what benefits could be payable for services and procedures over $300. Have your dentist fax your treatment plan to Guardian, note that it is a pre-determination review and we will let your dentist know what benefits would be payable.
- **Special Limitation:** Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan.
  R3 - DG2000

A late entrant is a person who becomes insured more than 31 days after he is eligible; or becomes insured again, after his coverage lapsed because he did not make required payments. We won't cover charges incurred by a late entrant for (1) Group II (basic) services until 6 months from the date he is insured by this plan; and (2) Group III (major) services until 12 months from the date he is insured by this plan

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

This handout is for illustrative purposes. You will receive benefit booklets. If there is a discrepancy between this handout and your benefit booklet, the benefit booklet prevails.

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Questions and Answers

The Guardian's Voluntary DentalGuard Maximum Rollover Program

What is Guardian's Voluntary DentalGuard Insurance?
An opportunity to help protect and care for your smile — and your family's at affordable group rates. You pay plan premiums through convenient payroll deduction.

Can I visit any dentist or specialist or only certain ones?
If you go to a DentalGuard Preferred Network Provider, the benefits described on the Benefit and Cost Summary will be paid based on a reduced fee schedule (this will mean less out-of-pocket). The network provider cannot balance bill charges in excess of the fee schedule and you get more services with your yearly maximum. If you go to a non-contracted dentist, the benefits will be based on usual, customary and reasonable rates for a given area.

What is a plan deductible and/or annual maximum?
A *deductible* is the dollar amount of covered dental expenses you must pay during the year before benefits are paid by The Guardian. An *annual maximum* is the maximum amount your dental plan will pay in benefits during the year. Both are generally based on the calendar year. Deductibles and annual maximums apply to each covered person.

What is a maximum rollover account?
With Maximum Rollover, we'll roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). The MRA can be used in future years, if you reach the plan's annual maximum.

Even better, if you use the services of Preferred Providers exclusively during the benefit year, we'll increase the amount credited to your MRA.

To qualify, you must submit a claim and not exceed the paid claims Threshold during the benefit year. You and your dependents maintain separate MRA's based on your own claim activity. Your MRA may not exceed the MRA Limit.

Maximum Rollover Plans based on a calendar year benefit period with a plan effective date in October, November or December; the plan features will be effective as of the first full benefit year. (Example: If a plan starts in November of 2005, claim activity in 2006 will be used and applied to MRAs for use in 2007).

What is co-insurance?
For some service categories, you may share in the cost of your dental expenses. This is represented as a percentage of the usual, customary, and reasonable level (if a non-network dentist is used) *or* a percentage of the negotiated fee for covered services (if a network dentist is used). The percentage of co-insurance usually depends on the type of service received: Preventive, Basic, or Major

What is a negotiated fee-for-service?
This refers to the set maximum fees for services that have been negotiated with our contracted network dentists and specialists. These average 30% less than the fees they usually charge.

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The Guardian Life Insurance Company of America, New York, NY 2004-7900

Questions and Answers

What is pre-treatment review?
For all courses of treatment expected to exceed $300, your dentist should submit a report to The Guardian describing the proposed treatment and itemizing expected charges. We will review the report and send the dentist an estimate of benefits we will pay. This will help ensure that you receive the best and most appropriate treatment necessary. Emergency treatment, oral examinations, cleaning, and x-rays may be performed before the review is prepared.

When I visit a dentist, are there any claim forms to fill out?
Network dentists have contracted with The Guardian to submit claim forms and accept benefits directly from The Guardian.

Some non-network dentists may submit claims directly to The Guardian. More often, however, non-network dentists will require that you pay for services at the time they are rendered. Afterwards, complete a simple claim form and forward it to us along with a copy of your payment receipt.

How can I find a network dentist or specialist near me?
You may either refer to your DentalGuard Preferred provider directory or locate a dentist on the Internet using our on-line listing at www.GuardianLife.com.

Do all my covered family members have to go to the same network or non-network dentists?
No. In fact, if they wanted to, every family member could go to a different network or non-network dentist *or* specialist, every time they need care.

What does usual, customary, and reasonable mean?
Usual, customary, and reasonable (UCR) charges for covered services are determined by using the usual level of charges made by the majority of dentists in the same geographic area for the same service. If your dentist's fee is lower than the UCR charge, the plan will pay benefits based on the actual fee. If the fee is higher, the plan will pay benefits based only on the UCR charge, and you are responsible for any amount above the UCR limit.

When will my coverage go into effect?
Your benefits coordinator will notify you when your coverage takes effect.

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