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**YOUR  
GROUP INSURANCE  
PLAN**

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**DELAWARE JOCKEYS ASSOCIATION, INC.  
CLASS 0002  
AD&D, DENTAL, LIFE, VISION**



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**CERTIFICATE OF COVERAGE**

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**The Guardian**  
7 Hanover Square  
New York, New York 10004

We, The Guardian, certify that the member named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

Group Policy No.	Certificate No.	Effective Date
Issued To		

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This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

B110.0055



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## GENERAL PROVISIONS

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As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan*.

"Covered person" means a *member* or a dependent insured by this *plan*.

"Our," "The Guardian," "us" and "we" mean The Guardian Life Insurance Company of America.

"Plan" means the Guardian *plan* of group insurance purchased by your *the planholder*.

"Planholder" means the Delaware Jockeys' Association, Inc., who purchased this plan.

"You" and "your" mean a *member* insured by this *plan*.

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### Incontestability

This *plan* is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this *plan* replaces a plan the *planholder* had with another insurer, we may rescind this *plan* based on misrepresentations made by the *planholder* or a *member* in a signed application for up to two years from the effective date of this *plan*.

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### Accident and Health Claims Provisions

Your right to make a claim for any *accident and health* benefits provided by this *plan*, is governed as follows:

**Notice** You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made for one of your *covered dependents*, his or her name should also be noted.

## Accident and Health Claims Provisions (Cont.)

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**Proof of Loss** We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

**Late Notice of Proof** We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

**Payment of Benefits** We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

**Limitations of Actions** You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.

**Workers' Compensation** The *accident and health* benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

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## ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

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### Member Coverage

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**Eligible Members** To be eligible for member coverage, you must be an active *full-time member*. And you must belong to a class of *members* covered by this *plan*.

**Other Conditions** You must:

- (a) be legally working in the United States; and
- (b) be regularly working as a licensed jockey and riding a minimum of 20 mounts per month each and every month.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

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**When Your Coverage Starts** Member benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

Member benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

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## Member Coverage (Cont.)

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**When Your Coverage Ends** Your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class of *members* eligible for insurance under this *plan*, or when this *plan* ends for all *members*. And it ends when this *plan* is changed so that benefits for the class of *members* to which you belong ends.

It ends on the date you are no longer working in the United States.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

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**GROUP TERM LIFE INSURANCE SCHEDULE**

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**Member Basic Term Life Insurance**

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**Your Basic Term Life Insurance Amount** Insurance Amount . . . . . \$25,000.00  
B265.0011

**Reduction of Basic Life Insurance Amount Based on Age** If a member is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 3500% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If a member is less than age 70 when his or her insurance under this plan starts, the member's insurance amount is reduced, when he or she reaches age 70, by 6000% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If a member is less than age 75 when his or her insurance under this plan starts, the member's insurance amount is reduced, when he or she reaches age 75, by 7500% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 75 but before he or she reaches age 80.

If a member is less than age 80 when his or her insurance under this plan starts, the member's insurance amount is reduced, when he or she reaches age 80, by 8500% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 80.

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**Limitations For Future Entrants** However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

## Member Basic Term Life Insurance (Cont.)

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If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than \$1,000.00.

If we do not approve the proof, your insurance amount will be \$1,000.00.

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## Member Basic Accidental Death and Dismemberment Insurance (AD&D)

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**Your Basic AD&D Insurance Amount** Insurance Amount . . . . . \$25,000.00  
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### Spousal Education and Retraining Benefit

**Lifetime Maximum Benefit** \$20,000

**Maximum Number Of Benefit Payments** Full-Time Post Secondary Education . . . . . 8  
Part-Time Post Secondary Education . . . . . 4

B265.0847

### Dependent Child Education Benefit

**Lifetime Maximum Benefit** \$20,000.00 per eligible dependent

**Maximum Number Of Benefit Payments** 8 per lifetime per eligible dependent

**Maximum Benefit Period** 6 years from the date the first education benefit is made; per eligible dependent.

B265.0848

**Reduction of Basic AD&D Amount Based on Age** If a member is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If a member is less than age 70 when his or her insurance under this plan starts, the member's insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

## Member Basic Accidental Death and Dismemberment Insurance (AD&D) (Cont.)

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The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If a member is less than age 75 when his or her insurance under this plan starts, the member's insurance amount is reduced, when he or she reaches age 75, by 75% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 75 but before he or she reaches age 80.

If a member is less than age 80 when his or her insurance under this plan starts, the member's insurance amount is reduced, when he or she reaches age 80, by 85% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to a member's initial insurance amount if his or her insurance starts after he or she reaches age 80.

B265.1270

### **Limitations For Future Entrants**

However, regardless of any of the above reductions, we limit the amount of insurance for which you are eligible if your insurance under this plan starts both: (a) after this plan's effective date; and (b) after you reach age 70.

If you provide us with proof of insurability, and we approve it in writing, the amount of your insurance will be 50% of the amount which otherwise applies to your classification and/or option. But in no event will this reduced amount be less than \$1,000.00.

If we do not approve the proof, your insurance amount will be \$1,000.00.

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**Your Group Term Life Insurance**

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- Basic Life Benefit** If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.
- Proof of Death** We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.
- Your Beneficiary** You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving the *planholder* written notice, unless you've assigned this insurance. But the change won't take effect until the *planholder* gives you written confirmation of the change.
- If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.
- If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.
- Assigning Your Life Insurance** If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.
- We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask the *planholder* for details or write to us.
- Payment to a Minor or Incompetent** If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.
- Payment of Funeral or Last Illness Expenses** We have the option of paying up to \$2,000.00 of this insurance to any person who incurs expenses for your funeral or last illness.
- Settlement Option** If you or your beneficiary ask us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

## Portability Privilege

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- Applicability** This provision applies only to this plan's member Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment with Catastrophic Loss Insurance.
- Important Restriction** You must provide proof of insurability satisfactory to us.
- Portability Of Basic Group Term Life Insurance** You may elect to continue all or part of your member Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.
- You may port your coverage if coverage under this plan ends because you: (a) have terminated active membership in the Delaware Jockeys' Association, Inc.; or (b) stop being a member of an eligible class of members.
- You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit.
- You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.
- You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least \$50,000.00.
- The Portable Certificate Of Coverage** You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan.
- The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.
- How To Port** To get a portable certificate of coverage, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.
- Defined Term** As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

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## Converting Your Group Term Life Insurance

<b>If Your Membership Ends or Eligibility Ends</b>	Your group life insurance ends if you stop being a member of an eligible class of <i>members</i> . If this happens, you can convert all or part of your group life insurance to an individual life insurance policy. The amount you can convert is limited to the amount of your insurance under this <i>plan</i> , less any group life benefits you become eligible for in the 31 days after this insurance ends.
<b>If The Group Plan Ends or Group Life Insurance is Dropped</b>	Your group life insurance also ends if this group <i>plan</i> ends, or if life insurance is dropped from the group <i>plan</i> for all <i>members</i> or for your class. If either happens and you've been insured by a Guardian group life plan for at least five years, you can also convert. But, the amount you can convert is limited to the lesser of: (a) \$10,000.00; or (b) the amount of your insurance under this <i>plan</i> , less any group life benefits you become eligible for in the 31 days after this insurance ends.
<b>The Converted Policy</b>	<p>You can convert to one of the policies we normally issue. It can't include disability benefits. And, it can't be a term policy.</p> <p>The premium for the converted policy will be based on: (a) your standard or sub-standard risk and rate class under this <i>plan</i>; and (b) your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion.</p>
<b>How and When to Convert</b>	To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you're insurable.
<b>Death During the Conversion Period</b>	If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.
<b>Notice of This Conversion Right</b>	If you're entitled to obtain a converted policy, the planholder must give you written notice of such right. Such notice must be given within 16 days after the date your group life insurance ends. If the planholder fails to give such notice at the proper time, you will have 15 days from the date such notice is given to convert, except that in no event will the time allowed to convert extend more than 91 days from the date the your group life insurance ends.

B275.0360

### SPOUSAL EDUCATION AND RETRAINING BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a spousal education and retraining benefit subject to all the terms below.

<b>When And How The Spousal Education And Retraining Benefit Begins</b>	<p>We will pay a spousal education and retraining benefit when all of the following conditions are met:</p> <ul style="list-style-type: none"><li>(a) a benefit is payable under this plan's Member Basic Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to a specified loss; and</li><li>(b) on the date of the accidental injury which results in the specified loss, you and your spouse share the same place of residence;</li></ul>
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## Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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- (c) we receive proof of the spouse's enrollment in an institute of higher learning. The spouse must: (i) be enrolled on the date of the accidental injury which results in the specified loss; or (ii) enroll within 12 months of this date.

**Specified Loss** means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Institute of Higher Learning** includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

**What We Pay** Subject to all the terms of this plan, the Spousal Education and Retraining Benefit per academic term is equal to the lesser of: (i) the spouse's net tuition expense for the term; (ii) 5% of the Member Basic ADDCL Benefit paid as a result of the specified loss; and (iii) \$2,500.00.

**Tuition Expense** means charges incurred for courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

**Net Tuition Expense** means tuition expense less any scholarships or grants to which the spouse is entitled.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. Benefit duration is based on whether the spouse is enrolled in a part-time or full-time course of study. See the Member Basic Accidental Death and Dismemberment Insurance Schedule.

**Continued Eligibility For The Spousal Education And Retraining Benefit** We require periodic proof of the spouse's continued enrollment in an institute of higher learning. The spouse must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent. We also require proof, per academic term, of: (a) the spouse's tuition expenses; and (b) any scholarships and grants the spouse is entitled to.

**When The Spousal Education And Retraining Benefit Ends** The spousal education and retraining benefit ends on the earliest of the following dates:

- (a) the date the spouse is no longer enrolled in an institute of higher learning;
- (b) the date the spouse fails to maintain a minimum grade point average as required above;
- (c) the date the spouse fails to furnish proof as required above;
- (d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; and

## Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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- (e) the date the maximum number of benefit payments, shown in the schedule, is reached.

B310.0976

### DAY CARE EXPENSE BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a Day Care Expense Benefit subject to all the terms below.

#### Eligibility For The Day Care Expense Benefit

This plan provides a day care expense benefit when all of the following conditions are met:

- (a) a benefit is payable under this plan's Member Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss; and
- (b) we receive proof of a qualified dependent's enrollment in a qualified day care program. Such enrollment must commence within 12 months of the date of the specified loss.

**Specified Loss** means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Qualified Dependent:** For purposes of the Day Care Expense Benefit a qualified dependent is: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) dependent upon you for main support and maintenance; and (c) under the age of seven on the date of the accidental injury which results in the specified loss.

**Qualified Day Care Program:** means a program of child care which: (i) is provided in a facility that is licensed as a day care center; or (ii) is operated by a licensed day care provider; and (iii) charges a fee for the care of children. A qualified day care program does not include child care provided by a parent, step-parent, grandparent, sibling, aunt or uncle.

**What We Pay** Subject to all the terms of this plan, the Day Care Expense Benefit is equal to the lesser of: (i) \$10,000 annually; or (ii) the actual annual day care expenses for all of your qualified dependents.

We pay this benefit quarterly, in arrears, upon receipt of proof of qualified day care expenses. Proof should be submitted within 30 days following the end of each calendar year quarter.

Payment will be made to the person who has primary responsibility for these expenses.

## Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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**Continued Eligibility For The Day Care Expense Benefit** We require periodic proof that a qualified dependent remains enrolled in a qualified day care program. We require periodic proof of the qualified dependent's day care expenses.

**When The Day Care Expense Benefit Ends** This plan's Day Care Expense Benefits end on the earliest of the following dates:

- (a) the date the dependent is no longer qualified, as defined above;
- (b) the date the dependent is no longer enrolled in a qualified day care program;
- (c) the date we do not receive proof of qualified day care expenses, as required by this plan; and
- (d) four years from the date the first day care expense benefit is paid.

B310.0977

### DEPENDENT CHILD EDUCATION BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay an education benefit on behalf of a qualified dependent, subject to all the terms below.

**When And How The Dependent Child Education Benefit Begins** We will pay a Dependent Child Education Benefit when all of the following conditions are met:

- (a) A benefit is payable under this plan's Member Basic Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss;
- (b) We receive proof of a qualified dependent's enrollment in an institute of higher learning. The dependent must be a full-time student, as defined by the institute.

**Specified Loss** means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury which results in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury which results in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Qualified Dependent:** To be qualified for the Dependent Child Education Benefit, a dependent must meet the following conditions. The dependent must be: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) unmarried; and (c) dependent upon you for main support and maintenance. On the date of the accidental injury which results in the specified loss, the dependent must be: (a) 22 years of age or younger; and (b) enrolled as a full-time student in an institute of higher learning; or (c) in the 12th grade, and enroll as a full-time student in an institute of higher learning within 12 months of this date. The dependent must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent.

## Your Basic Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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**Institute of Higher Learning** includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

**What We Pay** Subject to all the terms of this plan, the Dependent Child Education Benefit per academic term is equal to the lesser of: (i) the qualified dependent's net tuition expense for the term; (ii) 5% of the Basic ADDCL Benefit paid as a result of the specified loss; or (iii) \$2,500.00.

**Tuition Expense** means charges incurred for credit courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

**Net Tuition Expense** means tuition expense less any scholarships or grants to which the dependent is entitled.

We pay this benefit per academic term for each qualified dependent.

We pay this benefit to the person who has primary responsibility for these expenses.

**Continued Eligibility For Dependent Education Benefit** We require periodic proof that a dependent remains a qualified dependent, as defined above. We also require proof, per academic term, of: (a) the qualified dependent's tuition expenses; and (b) any scholarships and grants the dependent is entitled to.

**When The Dependent Child Education Benefit Ends** A qualified dependent's Dependent Child Education Benefit ends on the earliest of the following dates:

- (a) the date the dependent child is no longer a qualified dependent, as defined above;
- (b) the date the dependent fails to furnish proof as required above;
- (c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;
- (d) the date the maximum number of benefit payments, shown in the schedule, is reached; and
- (e) the date the maximum benefit period, shown in the schedule, is reached.

B310.0978

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## ELIGIBILITY FOR DENTAL COVERAGE

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B489.0002

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### Member Coverage

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**Eligible Members** To be eligible for *member* coverage you must be an active *full-time member*. And you must belong to a class of *members* covered by this *plan*.

**Other Conditions** If you must pay all or part of the cost of *member* coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this *plan* because you were covered under another group *plan*, and you now elect to enroll in the dental coverage under this *plan*, the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other *plan* ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's *plan*; (c) divorce; (d) death of your spouse; or (e) termination of the other *plan*.

But you must enroll in the dental coverage under this *plan* within 30 days of the date that any of the events described above occur.

B489.0339

**When Your Coverage Starts** *Member* benefits are scheduled to start on your effective date.

But you must be actively at work on a *full-time* basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active *full-time* work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a *full-time* basis on your last regularly scheduled work day.

B489.0340

**When Your Coverage Ends** Your coverage ends on the last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

It also ends on the date you stop being a member of a class of *members* eligible for insurance under this *plan*, or when this *plan* ends for all *members*. And it ends when this *plan* is changed so that benefits for the class of *members* to which you belong ends.

## Member Coverage (Cont.)

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If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

B489.0341

## Dependent Coverage

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B200.0271

**Eligible Dependents For Dependent Dental Benefits** Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 20; and (c) your unmarried dependent children from age 20 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan*. You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary*.

Legal spouse includes a partner to a civil union when that union is in accordance with Delaware law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

B489.0444

**Adopted Children And Step-Children** Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

**Dependents Not Eligible** We exclude any dependent who is insured by this *plan* as a *member*. And we exclude any dependent who is on active duty in any armed force.

B489.0342

**Handicapped Children** You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the *plan*, such a child may stay eligible for dependent benefits past this coverage's age limit.

## Dependent Coverage (Cont.)

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The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage's age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

B449.0042

### **Waiver Of Dental Late Entrants Penalty**

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

B200.0749

### **When Dependent Coverage Starts**

In order for your dependent coverage to begin you must already be insured for member coverage or enroll for member and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan*, the date your dependent coverage starts depends on when you elect to enroll your *initial dependents* and agree to make any required payments.

If you do this on or before your *eligibility date*, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your *eligibility date* and the date you become insured for member coverage.

If you do this within the *enrollment period*, the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for member coverage.

## Dependent Coverage (Cont.)

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If you do this after the *enrollment period* ends, each of your *initial dependents* is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

Once you have dependent coverage for your *initial dependents*, you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the *newly acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the *newly acquired dependent*, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant's coverage is scheduled to start on the date you sign the enrollment form.

B489.0345

**Exception** If a dependent, other than a newborn child, is confined to a *hospital* or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

B200.0692

**Newborn Children** We cover your newborn child for dependent benefits, from the moment of birth if: (a) you are already covered for dependent child coverage when the child is born; or (b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

B489.0019

**When Dependent Coverage Ends** Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain *eligible dependents*; and (c) in the case of a spouse, the spouse does not remarry.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of *members* eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all *members* or for an *member's* class.

If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.



## Dependent Coverage (Cont.)

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An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child at 12:01 a.m. on the date the child attains this coverage's age limit, when he or she marries, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.

B489.0343

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## DENTAL HIGHLIGHTS

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This page provides a quick guide to some of the Dental Expense Insurance *plan* features which people most often want to know about. But it's not a complete description of your Dental Expense Insurance *plan*. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- **Benefit Year Cash Deductible for Non-Orthodontic Services**

For Group I Services . . . . . None  
For Group II and III Services . . . . . \$50.00  
for each covered person

B497.0075

- **Payment Rates:**

For Group I Services . . . . . 100%  
For Group II Services . . . . . 80%  
For Group III Services . . . . . 50%  
For Group IV Services . . . . . 50%

B497.0086

- **Benefit Year Payment Limit for Non-Orthodontic Services**

For Group I, II and III Services . . . . . Up to \$3,000.00

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services . . . . . Up to \$2,000.00

**Note:** A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

B497.1432

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## DENTAL EXPENSE INSURANCE

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This insurance will pay many of a *covered person's* dental expenses. *We* pay benefits for covered charges incurred by a *covered person*. What *we* pay and terms for payment are explained below.

B498.0007

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### Covered Charges

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Covered charges are reasonable and customary charges for the dental services named in this *plan's* List of Covered Dental Services. To be covered by this *plan*, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

*We* may use the professional review of a *dentist* to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, *we* mean the charge is the *dentist's* usual charge for the service furnished. By customary, *we* mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists*. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan*, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, *we* may only pay benefits for the osseous surgery.

*We* only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan*. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

B498.0242

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## Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have 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 *us*. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

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## Proof Of Claim

So that *we* may pay benefits accurately, the *covered person* or his or her *dentist* must provide *us* with information that is acceptable to *us*. This information may, at *our* discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If *we* don't receive the necessary information, *we* may pay no benefits, or minimum benefits. However, if *we* receive the necessary information within 15 months of the date of service, *we* will redetermine the *covered person's* benefits based on the new information.

B498.0002

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## Pre-Treatment Review

When the expected cost of a proposed course of treatment is \$300.00 or more, the *covered person's dentist* should send *us* a treatment plan before he or she starts. This must be done on a form acceptable to *Guardian*. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to *us*.

A treatment plan should always be sent to *us* before orthodontic treatment starts.

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to *us*, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

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## Pre-Treatment Review (Cont.)

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Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won't deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

B498.0003

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## Benefits From Other Sources

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Other plans may furnish benefits similar to the benefits provided by this *plan*. For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. You may also be covered by this *plan* and a medical plan. In such instances, we coordinate *our* benefits with the benefits from that other plan. *We* do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

B498.0005

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## The Benefit Provision - Qualifying For Benefits

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B498.0072

**Penalty For Late Entrants** During the first 6 months that a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group IV Services.

Charges for the services we don't cover under this provision are not considered to be covered charges under this *plan*, and therefore can't be used to meet this *plan's* deductibles.

*We* don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan*.

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

B498.0231

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## Benefit Provision - Qualifying For Benefits (Cont.)

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**How We Pay  
Benefits For Group  
I, II And III  
Non-Orthodontic  
Services**

There is no deductible for Group I services. We pay for Group I covered charges at the applicable *payment rate*.

A *benefit year* deductible of \$50.00 applies to Group II and III services. Each *covered person* must have covered charges from these service groups which exceed the deductible before we pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Once a *covered person* meets the deductible, we pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year*.

B498.0187

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$3,000.00.

B498.0192

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## The Benefit Provision - Qualifying For Benefits

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A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

B498.2041

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## Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

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A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year*, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold*, he or she may be entitled to a *Reward*.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider*, he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider*.

*Rewards* can accrue and are stored in the *covered person's Bank*. If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank*. The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum*.

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this *plan's Rollover Threshold, Reward, and Bank Maximum* are:

## Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)

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- *Rollover Threshold* . . . . . \$1,000.00
- *Reward* (if all benefits are for services provided by a *preferred provider*) . . . . . \$750.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider*) . . . . . \$500.00
- *Bank Maximum* . . . . . \$1,500.00

If this *plan's* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year*. And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year*. In either case:

- only claims incurred on or after January 1 will count toward the *Rollover Threshold*; and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of this *plan* called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this *plan's* next *benefit year*, this rollover provision will not apply to the *covered person* until the next *benefit year*, and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold*; and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"*Bank*" means the amount of a *covered person's* accrued *Reward* .

"*Bank Maximum*" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank*.

"*Reward*" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold*.

"*Rollover Threshold*" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward*.

B498.2037

## The Benefit Provision - Qualifying For Benefits (Cont.)

### How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services only for covered dependent children who are less than 19 years old when the *active orthodontic appliance* is first placed.

We pay for Group IV covered charges at the applicable *payment rate*.

Using the *covered person's* original treatment *plan*, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic* appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. We limit what we pay for orthodontic services to the lifetime payment of \$2,000.00. What we pay is based on all of the terms of this *plan*.

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan*. We limit what we pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan*. Based on the original treatment *plan*, we determine the portion of charges incurred by the *covered person* prior to being covered by this *plan*, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment *plan* to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits we pay for *orthodontic treatment* won't be charged against a *covered person's* *benefit year* payment limits that apply to all other services.

B498.0058

### Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year*. Once this happens, we pay benefits for covered charges incurred by any *covered person* in that *covered family*, at the applicable *payment rate* for the rest of that *benefit year*. The charges must be incurred while the person is insured. What we pay is based on this *plan's* *payment limits* and to all of the terms of this *plan*.

B498.0073

### Payment Rates

Benefits for covered charges are paid at the following *payment rates*:

- Benefits for Group I Services . . . . . 100%
- Benefits for Group II Services . . . . . 80%
- Benefits for Group III Services . . . . . 50%
- Benefits for Group IV Services . . . . . 50%

B498.0084



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## After This Insurance Ends

We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan*, we'll pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis*, if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

B498.0233

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## Special Limitations

B498.0138

**Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan**

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan*. We won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan*.

B498.0133

**If This Plan Replaces The Prior Plan**

This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person*.

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan*; and (b) for which extraction benefits were paid by the *prior plan*.
- **Deductible Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's* deductibles required under this *plan*, by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.
- **Orthodontic Payment Limit Credit** - We reduce a *covered person's* orthodontic *payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

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## Exclusions

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We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.

## Exclusions (Cont.)

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- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis*; (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis*; unless (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- 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.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.

B498.2113

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## List of Covered Dental Services

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The services covered by this *plan* are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a *dentist*. And they must be usual and necessary treatment for a dental condition.

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### Group I - Preventive Dental Services (Non-Orthodontic)

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**Prophylaxis And Fluorides** Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to *covered persons* under age 14 and limited to 1 treatment(s) in any 6 consecutive month period.

**Office Visits, Evaluations And Examination** Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the same visit.

B498.4802

**Space Maintainers** Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

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## Group I - Preventive Dental Services (Cont.)

(Non-Orthodontic)

Recementation of space maintainer performed more than 12 months after the initial insertion

**Fixed And Removable Appliances** Fixed and Removable Appliances To Inhibit Thumbsucking - limited to *covered persons* under age 14 and limited to initial *appliance* only. Allowance includes all adjustments in the first 6 months after insertion.

B498.0164

**Radiographs** Allowance includes evaluation and diagnosis.  
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

Full mouth series, of at least 14 films including bitewings

Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal films - single films

B498.0165

**Dental Sealants** Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

B498.0166

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## Group II - Basic Dental Services

(Non-Orthodontic)

**Diagnostic Services** Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each *covered dental specialty* in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

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**Group II - Basic Dental Services (Cont.)**  
(Non-Orthodontic)

**Restorative Services** Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration  
Composite resin

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 24 consecutive month period. Stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

B498.1123

**Crown And  
Prosthodontic  
Restorative Services** Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay  
Crown  
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

Denture repairs, metal  
Denture repairs, acrylic  
Denture repair, no teeth damaged  
Denture repair, replace one or more broken teeth  
Replacing one or more broken teeth, no other damage

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**Group II - Basic Dental Services (Cont.)**  
(Non-Orthodontic)

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture relines, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the relines is done by the *dentist* who furnished the denture. Limited to relines done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture relines or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

B498.1122

**Endodontic Services** Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

Pulp capping, direct

Pulp capping, indirect - includes sedative filling.

Vital pulpotomy, only when root canal therapy is not the definitive treatment

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only

Root Canal Treatment

Root canal therapy

Root canal retreatment, limited to once per tooth, per lifetime

Treatment of root canal obstruction, no-surgical access

Incomplete endodontic therapy, inoperable or fractured tooth

Internal root repair of perforation defects

Other Endodontic Services

Apexification, limited to a maximum of three visits

Apicoectomy, limited to once per root, per lifetime

Root amputation, limited to once per root, per lifetime

Retrograde filling, limited to once per root, per lifetime

Hemisection, including any root removal, once per tooth

B498.0201

**Group II - Basic Dental Services (Cont.)**  
(Non-Orthodontic)

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**Periodontal Services** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of 1 prophylaxis or periodontal maintenance procedure(s) in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

B498.0202

**Periodontal Surgery** Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

- Gingivectomy, per tooth (less than 3 teeth)
- Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

- Gingivectomy or gingivoplasty, per quadrant
- Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
- Gingival flap procedure, including scaling and root planing, per quadrant
- Distal or proximal wedge, not in conjunction with osseous surgery
- Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier
- Bone replacement grafts, when the tooth is present



**Group II - Basic Dental Services (Cont.)**  
(Non-Orthodontic)

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Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

B498.0203

**Non-Surgical Extractions** Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth  
Root removal non-surgical extraction of exposed roots

**Surgical Extractions** Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal  
Surgical removal of residual tooth roots  
Surgical removal of impacted teeth

**Other Oral Surgical Procedures** Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant  
Removal of exostosis, per site  
Incision and drainage of abscess  
Frenulectomy, Frenectomy, Frenotomy  
Biopsy and examination of tooth related oral tissue  
Surgical exposure of impacted or unerupted tooth to aid eruption  
Excision of tooth related tumors, cysts and neoplasms  
Excision or destruction of tooth related lesion(s)  
Excision of hyperplastic tissue  
Excision of pericoronal gingiva, per tooth  
Oroantral fistula closure  
Sialolithotomy  
Sialodochoplasty  
Closure of salivary fistula  
Excision of salivary gland  
Maxillary sinusotomy for removal of tooth fragment or foreign body  
Vestibuloplasty

B498.1124

## **Group II - Basic Dental Services (Cont.)**

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(Non-Orthodontic)

**Other Services** General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this *plan*.

Injectable antibiotics needed solely for treatment of a dental condition.

B498.0206

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## Group III - Major Dental Services (Non-Orthodontic)

**Major Restorative Services** Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury*, and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or *injury*. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

### Single Crowns

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

### Inlays

Onlays, including inlay

Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

Cast post and core in addition to a unit of crown or bridge, per tooth

Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth

Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.

Abutment supported crown

Implant supported crown

Abutment supported retainer for fixed partial denture

Implant supported retainer for fixed partial denture

Implant/abutment supported removable denture for completely edentulous arch

Implant/abutment supported removable denture for partially edentulous arch

Implant/abutment supported fixed denture for completely edentulous arch

Implant/abutment supported fixed denture for partially edentulous arch

Dental implant supported connecting bar

Prefabricated abutment

Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

Surgical placement of implant body, endosteal implant

Surgical placement, eposteal implant

Surgical placement transosteal implant

## Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

### Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime

Radiographic/surgical implant index - limited to once per arch in any 24 month period

Repair implant supported prosthesis

Repair implant abutment

Implant removal

B498.1129

**Prosthodontic Services** Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics

Resin with metal

Porcelain

Porcelain with metal

Full cast metal

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance*.

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth

Upper, resin base, including any conventional clasps, rests and teeth

Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Lower, resin base, including any conventional clasps, rests and teeth

Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Interim partial denture (stayplate), upper or lower, covered on *anterior teeth* only

Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

B498.1132

## Group IV - Orthodontic Services

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**Orthodontic Services** Any covered Group I, II or III service in connection with *orthodontic treatment*.

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment*, Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment*, including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

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## ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

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### Member Vision Care Expense Coverage

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**Eligible Members** To be eligible for member coverage under this *plan*, you must be an active *full-time member*. And you must belong to a class of members covered by this *plan*.

B505.1192

**When Your Coverage Starts** Your coverage under this *plan* is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But you must be actively at work on a *full-time* basis on that date unless you are a *qualified retiree*. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are an active *full-time employee* and are not actively at work on that date, we will postpone your coverage until the date you return to active *full-time* work.

If you are a *qualified retiree*, you can not be confined in a health care facility on the scheduled effective date of coverage. If you are confined on that date, we will postpone your coverage until the day after you are discharged. And you must also have met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

Sometimes, the effective date shown on the sticker is not a regularly scheduled work day. But your coverage will still start on that date if you were actively at work on your last regularly scheduled work day.

B505.0073

**When Your Coverage Ends** Your coverage under this *plan* ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

It also ends on the date you stop being a member of a class eligible for insurance under this plan, or when this plan ends for all *members*. And it ends when this *plan* is changed so that benefits for the class of *members* to which you belong ends.

If you are required to pay part of the cost of this *plan* and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue vision care benefits for a limited time.

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### Dependent Vision Care Expense Coverage

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**Eligible Dependents For Dependent Vision Care Benefits** Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 20; and (c) your unmarried dependent children from age 20 until their 26 birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan*. You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary*.

Legal spouse includes a partner to a civil union when that union is in accordance with Delaware law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

B505.1311

**Adopted Children And Step-Children** Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

We exclude any dependent who is insured by this *plan* as an *member*. And we exclude any dependent who is on active duty in any armed force.

B505.1194

**Handicapped Children** You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself. Subject to all of the terms of this section and the *plan*, such a child may stay eligible for dependent vision care benefits past this *plan's* age limit.

The child will stay eligible as long as he stays unmarried and unable to support himself, if: (a) his conditions started before he reached this *plan's* age limit; (b) he became insured by this *plan* before he reached the age limit, and stayed continuously insured until he reached such limit; and (c) he depends on you for most of his support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

B505.0119

**When Dependent Coverage Starts** In order for your dependent coverage to begin, you must already be insured for member coverage, or become insured for member and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this *plan*, the date your dependent coverage starts is as follows.

Dependent coverage for your *initial dependents* is scheduled to start on the later of the date you become covered for member coverage and the date you acquire the *initial dependents*.

## Dependent Vision Care Expense Coverage (Cont.)

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Once you have coverage for your *initial dependents*, each *newly acquired dependent* will be covered as of the date he or she becomes eligible.

B505.1195

**Exception** If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

B505.0132

**Newborn Children** We cover your newborn child for dependent vision care benefits, from the moment of his or her birth.

B505.0154

**When Dependent Coverage Ends** Dependent coverage ends for all of your dependents when your member coverage ends. But if you die while insured, we'll automatically continue dependent vision care benefits for those of your dependents who are insured when you die. We'll do this for six months at no cost, provided: (a) the group *plan* remains in force; (b) the dependents remain *eligible dependents*; and (c) in the case of a spouse, the spouse does not remarry.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of members eligible for such coverage. And it ends when this *plan* ends, or when dependent coverage is dropped from this *plan* for all members or for a *member's* class.

If you are required to pay part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent's coverage ends when he stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the *member* for support and maintenance. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

Read this *plan* carefully if dependent coverage ends for any reason. Dependents may have the right to continue vision care benefits for a limited time.

B505.1196



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## VISION CARE HIGHLIGHTS

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This page provides a quick guide to some of the Vision Care Expense Insurance plan features which people most often want to know about. But it's not a complete description of your Vision Care Expense Insurance plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

<b>PPO Copayments</b>	Examinations . . . . .	\$10.00
	Standard Frames and/or Standard Lenses . . . . .	\$20.00
	Contact Lenses . . . . .	\$20.00
<b>Non-PPO Cash Deductibles</b>	Examinations . . . . .	\$10.00
	Standard Frames and/or Standard Lenses . . . . .	\$20.00
	Contact Lenses . . . . .	\$20.00

B505.0519

If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan's materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.

B505.0516

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## VISION CARE BENEFITS

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This insurance will pay many of a *member's* and his or her covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

B505.1197

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### This Plan's Vision Care Preferred Provider Organization

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**Davis Vision:** This *plan* is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Davis Vision's Preferred Provider Network.

This vision care *preferred provider* organization (PPO) is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from either a *preferred provider* or a *non-preferred provider*. And, he or she is free to change providers at any time. But, this *plan* usually pays more in benefits for covered services furnished by a vision care *preferred provider*. Conversely, it usually pays less for covered services not furnished by a vision care *preferred provider*.

When a *member* and his or her dependents enroll in this *plan*, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *preferred providers*.

What we pay is based on all of the terms of this *plan*. The *covered person* should read this material with care and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, frequencies, *copayments* and payment limits.

The *covered person* can call Davis Vision if he or she has any questions after reading this material.

**Choice of Preferred Providers** When a person becomes enrolled in this *plan*, he or she will receive information about Davis Vision *preferred providers* in his or her area. A *covered person* may receive vision services from any current Davis Vision *preferred provider*.

When a *covered person* wants to receive services from a *preferred provider*, he or she must contact the *preferred provider* before receiving treatment. The *preferred provider* will contact Davis Vision to verify the *covered person's* eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a *preferred provider*.

**Non-Preferred Providers** If a *covered person* receives services or supplies from a *non-preferred provider*, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

## This Plan's Vision Care Preferred Provider Organization (Cont.)

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Claims for services or supplies from a *non-preferred provider* must be sent to:

Davis Vision - Vision Care Processing Unit  
P.O. Box 1525  
Latham, NY 12110

B505.1198

## How This Plan Works

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We pay benefits for the covered charges a *covered person* incurs as follows. What we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

Covered charges are the *usual* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

B505.0472

**Copays** A *covered person* must pay a copay each time he or she receives a vision examination. A *covered person* must pay a copay each time he or she receives any vision materials covered by this *plan*.

B505.0474

**How We Cover Vision Examinations** A *covered person* must pay a \$10.00 copay each time he or she receives a vision examination. If the vision examination is performed by a *preferred provider*, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a *non-preferred provider*, we pay benefits in excess of the copay up to \$46.00.

We pay benefits for one vision examination in any 12 month period.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;

## How This Plan Works (Cont.)

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- biomicroscopy;
- gross visual fields;
- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

B505.0478

**How We Cover Vision Materials** We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or *lenticular lenses*. We pay benefits for frames. We pay benefits for prescription contact lenses.

In any 12 month period, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any 24 month period, we pay benefits for one set of frames.

B505.0806

**How We Cover Standard Lenses** A *covered person* must pay a \$20.00 copay each time he or she purchases *standard lenses*. If the lenses are received from a *preferred provider*, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a *non-preferred provider*, we pay benefits in excess of the copay up to:

- \$47.00 for single vision lenses;
- \$66.00 for bifocal lenses;
- \$85.00 for trifocal lenses; and
- \$125.00 for *lenticular lenses*.

We cover one pair of *standard lenses* in any 12 month period.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras;

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses (for children up to age 20 and monocular I individuals and *Covered Persons* with prescriptions of greater than +/-6.00 diopters);
- glass-grey #3 prescription sunglasses.

The following cosmetic lens extras are not covered. But if a *covered person* purchases his or her lenses from a *preferred provider*, the price will be discounted as follows:

- standard progressive addition lenses - \$50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - \$90

## How This Plan Works (Cont.)

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- photochromatic lenses - single vision or multifocal - \$20
- scratch resistant coating - single vision or multifocal - \$20
- ultra violet coating - \$12
- blended invisible bifocal lenses - \$20
- intermediate Lenses - \$30
- plastic photosensitive lenses - \$65
- polarized lenses - \$75
- hi-Index lenses - \$55
- supershield (scratchguard) coating - \$20
- glare resistant treatment (multi layer hydrophobic) - \$35
- premium glare resistant treatment - \$48

B505.0485

### How We Cover Elective Contact Lenses

We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of *standard lenses* and frames.

If we cover charges for elective contact lenses, we will not cover charges for *standard lenses* and frames for at least 12 months.

A *covered person* must pay a \$20.00 copay each time he or she purchases elective contact lenses.

If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the copay up to a maximum of \$105.00.

If the contact lenses are purchased from a *preferred provider*, we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a \$20.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of \$135.00. The copay is waived.

We cover one pair of elective contact lenses in any 12 month period.

B505.0836

### How We Cover Necessary Contact Lenses

We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of *keratoconus*; and
- the *covered person* complies with the following requirements regarding prior notification.

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## How This Plan Works (Cont.)

The *covered person* or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of *keratoconus* before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A *covered person* must pay a \$20.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a *preferred provider*, we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the copay up to a maximum of \$210.00.

B505.0489

**How We Cover Frames** A *covered person* must pay a copay each time he or she purchases a set of frames.

If the frames are purchased from a *non-preferred provider*, we pay benefits in excess of a \$20.00 copay up to \$47.00.

If the frames are purchased from a *preferred provider*, we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a \$20.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a \$45.00 copay.
- We cover a non-Tower frame in excess of a \$20.00 copay up to the retail frame allowance of \$135.00.

We cover one set of frames in any 24 month period.

B505.0490

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## Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental training.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an *employer* as a condition of employment.
- We won't pay for *plano lenses* (lenses with less than a +/- .38 diopter power).
- We won't pay for two sets of glasses in lieu of bifocals.
- We won't pay for replacement of lenses and frames furnished under this *Plan* which are lost or broken, except at normal intervals when services are otherwise available.

## Exclusions (Cont.)

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- We won't pay for necessary contact lenses prescribed for a *covered person* affected with *keratoconus* for which prior notification was not sent to Davis Vision.
- We won't pay for lens cosmetic extras that are not specifically listed in this *Plan* as covered.

B505.0492

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## COORDINATION OF BENEFITS

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**Important Notice** This section applies to all group health benefits under this plan; except prescription drug and vision coverage, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

**Purpose** When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

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### Definitions

**Allowable Expense** This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.
- (2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
- (3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- (4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.



## Definitions (Cont.)

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If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

- Claim** This term means a request that benefits of a plan be provided or paid.
- Claim Determination Period** This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.
- Coordination Of Benefits** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- Custodial Parent** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- Group-Type Contracts** This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.
- Hospital Indemnity Benefits** This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group or group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of \$100.00 per day; (6) medical benefits under group, group-type, and individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.
- This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of \$100.00 or less per day; (ii) school accident type coverage; or (iii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.
- This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

## Definitions (Cont.)

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Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

**Primary Plan** This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

**Secondary Plan** This term means a plan that is not a primary plan.

**This Plan** This term means the group health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

B555.0229

## Order Of Benefit Determination

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The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

**Non-Dependent Or Dependent** The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

**Dependent Child Covered Under More Than One Plan** The order of benefit determination when a child is covered by more than one plan is:

## Order Of Benefit Determination (Cont.)

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- (1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
- (2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

At the request by either parent of a dependent child, a group health benefits plan will issue an insurance card showing proof of applicable insurance for the dependent child to the parent making such request.

If benefits are not assigned and would be paid to an individual other than the provider, a group health benefits plan will issue the benefits to the parent who sought the treatment for the dependent child.

**Active Or Inactive Employee** The plan that covers a person as an active employee, or as that person's dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person's dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

**Continuation Coverage** The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person's dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

**Length Of Coverage** The plan that covered the person longer is primary.

**Other** If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

B555.0380

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## **Effect On The Benefits Of This Plan**

<b>When This Plan Is Primary</b>	When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.
<b>When This Plan Is Secondary</b>	When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

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## **Right To Receive And Release Needed Information**

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

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## **Facility Of Payment**

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

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## **Right Of Recovery**

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

B555.0232

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## GLOSSARY

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This Glossary defines the italicized terms appearing in your booklet.

B750.0100

**Active Orthodontic** means an *appliance*, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

B750.0663

**Anterior Teeth** means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

B750.0664

**Appliance** means any dental device other than a *dental prosthesis*.

B750.0665

**Benefit Year** means a 12 month period which starts on January 1st and ends on December 31st of each year.

B750.0666

**Blended Lenses** means bifocals which do not have a visible dividing line.

B750.0781

**Coated Lenses** means substance added to a finished lens on one or both surfaces.

B750.0782

**Copay** means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* before any benefits are paid by this *plan*.

B750.0783

**Covered Dental Specialty** means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist*: restorative/prosthetic services; endodontic services, periodontic services, oral surgery and pedodontics.

B750.0667

**Covered Family** means a member and those of his or her dependents who are covered by this *plan*.

B750.0857

**Covered Person** means a member or any of his or her covered dependents.

B750.0858

**Covered Person** with respect to vision care insurance means a *member* or *eligible dependent* who meets this *plan's* eligibility criteria and who is covered under this *plan*.

B750.0859

- Customary** means, when referring to a covered charge, that the charge for the covered vision condition is not more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.  
B750.0785
- Dental Prosthesis** means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.  
B750.0670
- Dentist** means any dental or medical practitioner we are 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*.  
B750.0671
- Eligibility Date** for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.  
B750.0064
- Eligible Dependent** is defined in the provision entitled "Dependent Coverage."  
B750.0065
- Emergency Treatment** means bona fide emergency services which: (a) 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 (b) are covered by this *plan*.  
B750.0672-R
- Enrollment Period** with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.  
B750.0074
- Full-time** means the member is a licensed jockey and rides a minimum of 20 mounts per month each and every month.  
B750.0862
- Initial Dependents** means those *eligible dependents* you have at the time you first become eligible for *member* coverage. If at this time you do not have any *eligible dependents*, but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents*.  
B750.0863
- Injury** means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan*, and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.  
B750.0673

## Glossary (Cont.)

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<b>Keratoconus</b>	means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.	B750.0786
<b>Lenticular Lenses</b>	means high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.	B750.0787
<b>Member</b>	means a person who is a member of the active membership class as defined in the Bylaws of the Delaware Jockeys' Association, Inc., and enrolled in this plan.	
<b>Newly Acquired Dependent</b>	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	B750.0865
<b>Non-Preferred Provider</b>	with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the <i>covered persons</i> of the <i>plan</i> .	B750.0788
<b>Orthodontic Treatment</b>	means the movement of one or more teeth by the use of <i>active appliances</i> . it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.	B750.0675
<b>Orthoptics</b>	means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	B750.0789
<b>Oversize Lenses</b>	means larger than a standard lens blank to accommodate prescriptions.	B750.0790
<b>Payment Limit</b>	means the maximum amount this <i>plan</i> pays for covered services during either a <i>benefit year</i> or a <i>covered person's</i> lifetime, as applicable.	B750.0676
<b>Payment Rate</b>	means the percentage rate that this <i>plan</i> pays for covered services.	B750.0677
<b>Photochromic Lenses</b>	means lenses which change color with the intensity of sunlight.	B750.0791

## Glossary (Cont.)

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<b>Posterior Teeth</b>	means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.	B750.0679
<b>Plan</b>	means the Guardian group dental plan purchased by the planholder.	
<b>Planholder</b>	means the Delaware Jockeys' Association, Inc.	B750.0866
<b>Plan</b>	means the Davis Vision plan of vision care services described herein.	B750.0792
<b>Plano Lenses</b>	means lenses which have no refractive power (lenses with less than a +/- .38 diopter power).	B750.0793
<b>Preferred Provider</b>	with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of <i>covered persons</i> of the <i>plan</i> .	B750.0794
<b>Prior Plan</b>	means the planholder's plan or policy of group dental insurance which was in force immediately prior to this <i>plan</i> . To be considered a prior plan, this <i>plan</i> must start immediately after the prior coverage ends.	B750.0681
<b>Proof Of Claim</b>	means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.	B750.0682
<b>Proof or Proof of Insurability</b>	means an application for insurance showing that a person is insurable.	B750.0099
<b>Qualified Retirees</b>	are covered as outlined in your company's benefit provisions. Please see your Plan Administrator for details.	B750.0105
<b>Standard Lenses</b>	means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.	B750.0795



**Tinted Lenses** means lenses which have an additional substance added to produce constant tint.

B750.0796

**Usual** means when referring to a covered charge that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

B750.0797

**We, Us, Our And Guardian** mean The Guardian Life Insurance Company of America.

B750.0683

## **The Guardian's Responsibilities**

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B752.0043

The dental expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of member certificates of insurance, and changes to such certificates.

B752.0044

The vision care expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of member certificates of insurance, and changes to such certificates.

B752.0045

The Guardian is located at 7 Hanover Square, New York, New York 10004.

B752.0046

## **Life And Accidental Death And Dismemberment Insurance Claims Procedure**

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Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA")

- (a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.
- (b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.
- (c) If a claim is denied, Guardian will provide a notice that will set forth:
  - (1) the specific reason(s) the claim was denied;
  - (2) specific references to the pertinent plan provision on which the denial is based;
  - (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
  - (4) an explanation of the plan's claim review procedure. A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.
- (d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

B800.0079

## Termination of This Group Plan

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The *planholder* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if the *planholder* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue or convert your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0007-R

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## **YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE**

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**[www.GuardianAnytime.com](http://www.GuardianAnytime.com)**

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

[GuardianAnytime.com](http://GuardianAnytime.com) - 24 hours a day, 7 days a week.

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

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

To register, go to [www.GuardianAnytime.com](http://www.GuardianAnytime.com)

