GUARDIAN

Dental Program

offered to the employees of

Axios Incorporated

Preventive Services	Basic Services	Major Services	Orthodontia
Deductible Waived	$50 Deductible		Deductible Waived
100%	**80%**	**50%**	**50%**
Emergency Treatment Oral Examinations X-Rays Teeth Cleaning *Space Maintainers *Topical Sealants *Fluoride Treatment *=For children only	Minor Restorative Services Biopsy and Examination of oral tissue Laboratory Tests Anesthesia Repair & Maintenance of Bridgework Periodontic Services, Including Oral Surgery Fillings & Extractions Endodontics, including Root Canal	Gold & Porcelain Fillings & Crowns Installation of Bridgework Installation of Crowns Dentures Inlays Onlays, in addition to inlay allowance	Child Orthodontia to age 19 50% to $1000 Lifetime Maximum

Deductible: $50 – 3 per Family
Annual Plan Maximum per person: $1000
Orthodontia Lifetime Maximum: $1000

Provider Information at: www.guardianlife.com, Provider Online Search, Find a Dentist, PPO plan, DentalGuard Preferred Network

Eligible Dependents: Your legal spouse; your unmarried dependent children who are under age 20; and your unmarried dependent children, from age 20 until their 26th birthday, who are enrolled as full-time students at accredited schools.

All benefits are based on usual, customary, and reasonable rates for a given area.

Late Entrants: Except for covered charges due solely to an accident he suffers while insured, we won't pay benefits for any charges incurred by a late entrant in the first: 1) 6 months he is insured for Basic Services; 2) 12 months he is insured for Major Services; and 3) 24 months he is insured for Orthodontic Services. A late entrant is any person who: 1) becomes insured more than 31 days after he is first eligible; or 2) becomes insured again, after his coverage lapsed because required payments were not made.

Guardian, Group Dental Claims: PO Box 2459, Spokane, WA 99210-2459 1-800-541-7846

GUARDIAN

DentalGuard True Group
The Fine Print

This document is a summary of your dental plan. * A complete list of covered services, limitations and exclusions is in your plan document and certificate booklet. The plan pays for covered charges to prevent, diagnose or treat dental disease, defect or injury. Payment is subject to all provisions of the group plan. Insured employees and their qualified insured dependents are covered persons.

Covered Charges: Covered charges are reasonable and customary charges for the dental services named in the List of Covered Dental Services. To be covered, a service must be (a) necessary; (b) appropriate for a given condition; and (c) on the list of covered services. 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.

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 policy, these less extensive procedures are considered to be part of the more comprehensive procedure.

We only pay for covered charges incurred by a covered person while he or she is insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is first prepared. A covered charge for any other appliance or 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. All other covered charges are incurred on the date the services are furnished, and if a service is started while insured, it must be completed within 31days to be considered for coverage.

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.

Benefits From Other Plans: If a covered person receives benefits from another plan other than one sponsored by his employer or Medicare, we will coordinate our payments with the benefits from that plan. We do this so the covered person won't receive benefits which exceed the charges incurred. Benefits from other plans cannot be used to meet this plan's deductible.

Deductible: Benefits are paid for covered charges following the payment of a personal cash deductible, which is shown in the Schedule of Benefits.

Family Deductible Limit: If three family members pay the cash deductible in a benefit year, the deductible for all other insured family members will be waived for the rest of that year.

*Please note that due to state mandates, a plan may be slightly different than described in this document.

Payment Rate: After the deductible is satisfied, the plan pays covered charges for preventive, basic, and major services. All benefits are subject to the payment rates and maximum amount payable in any benefit year as shown in the Schedule of Benefits.

Pre-Treatment Review: For all courses of treatment expected to exceed $300 we ask the dentist to submit a report to Guardian describing the proposed treatment and itemizing expected charges.

Proof of Claim: In order to accurately pay for and determine covered charges, it is required that information acceptable to Guardian be provided. This information may, at Guardian's discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials which document proof of claim and support the necessity of the proposed treatment. If the necessary information is not provided, no benefit or minimum benefits may be allowable.

Late Entrants: Except for covered charges due solely to an accident suffered while insured, we won't pay benefits for any charges incurred by a late entrant in the first: (1) 6 months he or she is insured for basic services; (2) 12 months he or she is insured for major services; and (3) if included in the plan, 24 months he or she is insured for orthodontic services. A late entrant is any person who: (1) becomes insured more than 31 days after he is first eligible; or (2) becomes insured again after his coverage lapsed because required payments were not made.

Missing Teeth: A covered person may have one or more congenitally missing teeth or have had one or more teeth lost or extracted before he or she became insured 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 insured by this plan.

Replacement of Prior Plan: This plan may be replacing the prior plan your employer had with another insurer. If: (1) the covered person was insured by the prior plan; and (2) the covered person was insured by this plan from the start, subject to all other provisions of this plan, the following provisions apply:

- ❑ Teeth Extracted While Insured With the Prior Plan - the limitation on an appliance or dental prosthesis which replace teeth that were lost prior to being insured does not apply to the appliance or dental prosthesis which replaces teeth that were extracted and covered by the prior plan. You are required to supply us with proof that the tooth was extracted and covered by the prior plan.
- ❑ Deductible Credit and Benefit Year Maximum Credit - in the first benefit year of this plan, we reduce this plan's deductible by the amount of covered charges applied against the prior plan's deductible and in the first benefit year of this plan, we reduce the maximum benefit payable under this plan by the amount paid under the prior plan. You are required to supply us with proof of the amount of deductible and maximum applied against the prior plan's deductible.

Exclusions: The plan does not pay for:
1) Any restoration, procedure, appliance or dental prosthesis used solely to: (a) alter vertical dimension; (b) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (c) treat a condition caused by attrition or abrasion; or (d) splint or stabilize teeth for periodontal reasons.
2) Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis.
3) Any service or procedure associated with the placement, repair, maintenance or removal of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.
4) Any service furnished solely for cosmetic reasons.
5) Replacing an existing appliance or dental prosthesis with a like appliance or dental prosthesis or any appliance or dental prosthesis; unless (a) it is at least 10 years old and can't be made usable; or (b) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be made serviceable.
6) The replacement of extracted or missing third molars/wisdom teeth.
7) Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
8) Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
9) Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
10) Treatment needed due to: (a) an on-the-job or job-related injury; or (b) a condition for which benefits are payable by Worker's Compensation or similar laws.
11) Treatment for which no charge is made. This usually means treatment furnished by: (a) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (b) a facility owned or run by any governmental body; and (c) any public program, except Medicaid, paid for or sponsored by any government body.
12) Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
13) Orthodontic treatment, unless the benefit provision provides specific benefits or orthodontic treatments.
14) Any procedure performed in conjunction with, as part of or related to a non-covered procedure.
15) Any procedure not specifically listed as a covered benefit

Preventive Services

Oral Exams, Evaluations and Office Visits:

- ❑ Office visits, evaluations, examinations, re-evaluations - a total of one in any six-month period.
- ❑ Emergency oral evaluations - a total of one in any six-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 visit - a total of one in a six-month period.

Covered only when no other treatment, other than radiographs, is performed in the same visit.

Prophylaxis: A total of one prophylaxis or periodontal maintenance procedure (considered under Periodontal Services) in any six-month period.

Fluoride Treatment (Topical Application): Covered persons under age 14, one treatment in any six-month period.

Space Maintainers: Under age 16, initial appliance only.

Fixed and Removable Appliances to Inhibit Thumbsucking: Covered persons under age 14, initial appliance only.

Radiographs:

- ❑ Full mouth, complete series or panoramic radiograph - Either, but not both, once in any 60-month period.
- ❑ Bitewing films - Either a maximum of four bite-wing films or a set (seven to eight films) of vertical bitewings, in one visit, once in any 12-month period.
- ❑ Intraoral periapical or occlusal films, single films

Topical Sealants: One treatment on unrestored permanent molar teeth in any 36-month period and restricted to covered persons under age 16.

Basic Services

Diagnostic consultation for covered services with a dentist other than the one providing treatment. Once in 12-months for each dental specialty. We pay only if no other treatment, other than radiographs, is rendered during the visit.

Diagnostic Casts: When needed to prepare a treatment plan for complex treatment.

Histopathologic Examinations: When performed in conjunction with a tooth-related biopsy.

Basic Restorative Services: Multiple restorations on one surface are considered one restoration. 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 of this insert.

- ❑ Amalgam restorations
- ❑ Resin restorations (anterior teeth only).

Coverage for resins on posterior teeth is limited to the corresponding amalgam benefit. Restorations that do not involve the incisal edge are considered a single surface filling.

- ❑ Stainless steel crown, prefabricated resin crown, and resin based composite crown, once per tooth in any 24-month period. Temporary and provisional crowns are considered to be part of the permanent restoration.

Crown and Prosthetic Restorative Services: Also see the 'Major Restorative Services' section of this insert.

- ❑ Crown, bridge and denture repairs
- ❑ Recementation of inlay or onlay, crown and bridge, recementations performed more than 12-months after the initial insertion
- ❑ Adding teeth to partial dentures to replace extracted natural teeth
- ❑ Denture rebase, once per denture in any 24-month period
- ❑ Denture reline, full or partial denture - once per denture in any 24-month period
- ❑ Denture adjustments
- ❑ Tissue conditioning - a maximum of one treatment, per arch, in any 12-month period

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, permanent teeth
- ❑ Vital pulpotomy
- ❑ Root canal retreatment
- ❑ Apexification, a maximum of three visits
- ❑ Apicoectomy, once per root, per lifetime
- ❑ Root amputation, once per root, per lifetime
- ❑ Retrograde filling, once per root, per lifetime
- ❑ Hemisection, including any root removal, once per tooth

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 - a total of one prophylaxis (covered under Preventive) or periodontal maintenance procedure in any six-month period. 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, once per quadrant in any 24-month period.
- ❑ Full mouth debridement, once in any 36-month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36-month period.

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.

- ❑ Either Gingivectomy or Crown lengthening, once per tooth in any 12-month period.
- ❑ One of the following once per quadrant, in any 36-month period: (a) Gingivectomy or gingivoplasty, per quadrant; (b) Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant; (c) Gingival flap procedure, including scaling and root planing, per quadrant; (d) Distal or proximal wedge, not in conjunction with osseous surgery; (e) Surgical revision procedure, per tooth.
- ❑ One of the following, once per quadrant in any 36-month period: Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present.
- ❑ Either guided tissue regeneration or bone replacement grafts, once per area or tooth, per lifetime.

(a) Limited occlusal adjustment - a total of two visits, covered only when done within a six-month period after covered scaling and root planing or osseous surgery; (b) Occlusal guards, covered only when done within a six-month period after osseous surgery, once per lifetime.

Oral Surgery: 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.

- ❑ Uncomplicated extraction, one or more teeth
- ❑ Root removal - non-surgical extraction of exposed roots
- ❑ Surgical removal of erupted teeth, residual tooth roots and impacted teeth
- ❑ Alveoloplasty
- ❑ Removal of exostosis, maxilla or mandible
- ❑ 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, hyperplastic tissue, pericoronal gingiva
- ❑ Excision or destruction of tooth related lesion(s)
- ❑ Vestibuloplasty

Other Services: General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered surgical procedures.

Major Services

Major Restorative Services: Full and 3/4 cast metal and porcelain 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 of this insert.

Prosthodontic Services: Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement:

- ❑ Bridge abutments and Bridge pontics
- ❑ Complete or Immediate dentures, upper or lower
- ❑ Upper and lower partial dentures - allowance includes base, clasps, rests and teeth
- ❑ Interim partial denture (stayplate), covered on anterior teeth only
- ❑ Removable unilateral partial, one piece cast metal, including clasps and teeth