

Southern California Community Rated Dental PPO Plan Z-3 10-50 Employees

In-Network Services

\$50 Deductible (3 per family)		
100% Preventive Services	90% Basic Services	50% Major Services
Emergency Treatment Oral Examinations X-Rays Teeth Cleaning Children coverage for: Flouride Treatments (1) Topical Sealants (2) Space Maintainers (2)	Fillings - Amalgam Silicate & Acrylic Periodontic Services Root Canal Oral Surgery	Gold and Porcelain Fillings and Crowns Installation of bridgework and crowns
(1) under age 14 (2) under age 16		50% Employee Copayment
	10% Employee Copayment	
\$1500 per person annual maximum		

*Reimbursement based on Fee Schedule

Out-of-Network Services

\$50 Deductible (3 per family)		
80% Preventive Services	80% Basic Services	50% Major Services
Emergency Treatment Oral Examinations X-Rays Teeth Cleaning Children coverage for: Flouride Treatments (1) Topical Sealants (2) Space Maintainers (2)	Fillings - Amalgam Silicate & Acrylic Periodontic Services Root Canal Oral Surgery	Gold and Porcelain Fillings and Crowns Installation of bridgework and crowns
(1) under age 14 (2) under age 16		50% Employee Copayment
20% Employee Copayment	20% Employee Copayment	
\$1500 per person annual maximum		

*Reimbursement based on UCR 90th percentile

Area	Zip Codes	Employee	Employee + Spouse	Employee + Child(ren)	Family
Los Angeles (Area)	906-918	42.51	85.49	88.72	131.70
Los Angeles (City)	900-905	41.94	84.35	87.54	129.95
Bakersfield, San Luis Obispo	932-934	32.57	65.49	67.96	100.89
San Diego	919-921	40.48	81.41	84.49	125.42
Anaheim, Ventura	926-928, 930	41.86	84.18	87.36	129.68
Mojave, Santa Barbara, San Bernadino, Riverside	922-925, 931, 935	36.79	73.99	76.78	113.98
Las Vegas, NV	890-891	31.16	62.12	64.45	95.42

RATES VALID FOR QUOTES MADE FROM 1/1/03 to 6/30/03

Underwriting Requirements:

Plan requires 75% participation of full-time employees and dependents.
For Multi Area Quotes, contact your sales office.
Dependent children covered up to age 20, or age 26 if full-time student.

Above rates are for groups that currently have dental coverage (a copy of current carrier's bill is required as proof of coverage). If group does not currently have dental coverage increase above rates by 3%.

For plans where the entire group is non-contributory, multiply above rates by .95
Contact your sales office for additional plan designs.

Excludes the following occupations			
Insurance and Real Estate	64xx, 653x	Sports Teams	7999
Government Employees	43xx, 91xx - 97xx	Entertainers	792x
Agriculture	074x	Dentists	802x
Legal Services	81xx	Automobile Sales and Service	55xx
Teachers	821x - 822x, 8243 - 8244, 8249, 829x		

For rates for these occupations, please contact your sales office.

Benefit Variations:

(1)	For \$750 Maximum Benefit plans, multiply above rates by 0.83C	(2)	To increase the deductible from \$50 to:
	For \$1000 Maximum Benefit plans, multiply above rates by 0.893		\$75 - multiply above rates by .952
	For \$2000 Maximum Benefit plans, multiply above rates by 1.085		\$100 - multiply above rates by .922

DentalGuard Dental Insurance Plan General Limitations and Exclusions:

This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under Preventive Services), orthodontic (unless expressly provided for), cosmetic or experimental treatments, any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. GP-1-DNTL-90-1 et al.