



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSIT  
Y  
CLASS 0001  
DENTAL**

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

**This Booklet Includes All Benefits For Which You Are Eligible.**

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

**"Please Read This Document Carefully".**



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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 employee 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		

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.

**The Guardian** Life Insurance Company of America

*Stuart J Shaw*  
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3

B110.0023



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**Option B**

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**GENERAL PROVISIONS**

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As used in this booklet:

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

"Employer" means the *employer* who purchased 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 *employer*.

"You" and "your" mean an *employee* insured by this *plan*.

CGP-3-R-GENPRO-90

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**Option B**

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**Limitation of Authority**

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90

B160.0004

**Option B**

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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 made by a person insured under this *plan* shall be used in contesting the validity of his or her 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 or her lifetime. The application must be signed by the covered person and a copy furnished to him or her or his or her beneficiary.

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

CGP-3-R-INCY-NY-01

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## Dental Claims Provisions

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Your right to make a claim for any dental 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.

**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 120 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 all dental benefits to which you're entitled as soon as we receive written proof of loss.

We pay all dental benefits to you, if you're living. If you're not living, we have the right to pay all dental 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.

When you file proof of loss, you may direct us, in writing, to pay dental 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 dental benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CGP-3-R-AHC-90

B160.0129

## Option B

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### **An Important Notice About Continuation Rights**

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if: (a) the employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to the employee.

CGP-3-R-NCC-87

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## YOUR CONTINUATION RIGHTS

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### Federal Continuation Rights

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**Important Notice** This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies only to any dental, out-of-network point-of-service medical, medical expense, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this section.

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

**Conversion** Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

**If Your Group Health Benefits End** If your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

The continuation: (a) may cover you or any other qualified continuee; and (b) is subject to "When Continuation Ends".

**Extra Continuation for Disabled Qualified Continuees** If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

## Federal Continuation Rights (Cont.)

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To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee's family by your employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

CGP-3-R-COBRA-96-1

B235.0627

### Option B

**If You Die While Insured** If you die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

CGP-3-R-COBRA-96-2

B235.0075

### Option B

**If Your Marriage Ends** If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

**If a Dependent Child Loses Eligibility** If a dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

**Concurrent Continuations** If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

## Federal Continuation Rights (Cont.)

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**Special Medicare Rule** If you become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from your termination of employment or reduction of work hours; or (b) 36 months from the date of your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

**The Qualified Continuee's Responsibilities** A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date on which an event that would qualify a person for continuation under this section occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice.

Notice of a disability determination must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

CGP-3-R-COBRA-96-3

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## Option B

**Your Employer's Responsibilities** A qualified continuee must be notified, in writing, of: (a) his or her right to continue this plan's group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

Your employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) your death; (b) termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) Medicare entitlement; or (d) if you are a retired employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to the employer. Upon receipt of notice of a qualifying event from your employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan's group health benefits no later than 14 days after receipt of notice.

If your employer is also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, your employer must provide notice to a qualified continuee of the right to continue this plan's group health benefits within 44 days of the qualifying event.

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

**Your Employer's Liability** Your employer will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) he or she fails to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group health benefits to end; or (b) he or she fails to notify the qualified continuee of his or her continuation rights, as described above.

**Election of Continuation** To continue his or her group health benefits, the qualified continuee must give your employer written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from your employer as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to your employer, by the qualified continuee, in advance, at the times and in the manner specified by your employer. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by your employer.

## Federal Continuation Rights (Cont.)

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If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment of Premiums** A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless your employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to your employer.

**When Continuation Ends** A qualified continuee's continued group health benefits end on the first of the following:

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;
- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

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## Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under this *plan* as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If your group health benefits under this *plan* would otherwise end because you enter into active military service, this *plan* will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this *plan*.

Coverage under this plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments.

CGP-3-R-COBRA-96-4

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Option B

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**ELIGIBILITY FOR DENTAL COVERAGE**

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B489.0002

Option B

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**Employee Coverage**

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

**Other Conditions** If you must pay all or part of the cost of *employee* 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.

CGP-3-EC-90-1.0

B489.0122

Option B

**Dental Plan Election Procedures** Since Managed DentalGuard is offered to you as an alternative to this dental coverage, you may change your election, and enroll in Managed DentalGuard as follows.

If you drop your coverage under this *plan*, at any time other than during an open enrollment period, you may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If you remain covered under this plan, you may change your election, and enroll in Managed DentalGuard during an open enrollment period. Your coverage under this *plan* ends on the date coverage under Managed DentalGuard begins.

An "open enrollment period" is a 30 day period occurring once every 12 months after this plan's effective date, or at time intervals agreed upon by the *employer* and us.

If you change your election, your covered dependents will automatically be switched to Managed DentalGuard at the same time as you.

CGP-3-EC-90-1.0

B489.0137

**Option B**

**When Your Coverage Starts** *Employee* 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.

CGP-3-EC-90-2.0

B489.0070

**Option B**

**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 *employees* eligible for insurance under this *plan*, or when this *plan* ends for all *employees*. And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

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.

CGP-3-EC-90-3.0

B489.0075

**Option B**

**Your Right To Continue Group Coverage During  
A Family Leave Of Absence**

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**Important Notice** This section may not apply. You must contact your *employer* to find out if your *employer* must allow for a leave of absence under federal law. In that case the section applies.

## Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

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**If Your Group Coverage Would End** Group coverage may normally end for an *employee* because he or she ceases work due to an approved leave of absence. But, the *employee* may continue his or her group coverage if the leave of absence has been granted: (a) to allow the *employee* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the *employee's* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the *employee* is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The *employee* will be required to pay the same share of the premium as he or she paid before the leave of absence.

**When Continuation Ends** Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an *employee* who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the *employee* under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other *employee*; or (b) any later 12 month period in the case of an *employee* who cares for a covered servicemember.
- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

**Definitions** As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

## Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

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- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

B449.0727

### Option B

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#### Dependent Coverage

B200.0271

### Option B

**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*.

CGP-3-DEP-90-2.0

B489.0301

### Option B

**Adopted And Step-Children** Your "unmarried dependent children" include your dependent 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 the 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 an *employee*. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-91-3.1-NY

B489.0003

## Option B

**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.

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.

CGP-3-DEP-90-4.0

B449.0042

## Option B

**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.

CGP-3-DEP-90-5.0

B200.0749

### Option B

**When Dependent Coverage Starts** In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee 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 employee 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 employee coverage.

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.

CGP-3-DEP-90-6.0

B489.0055

### Option B

**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.

CGP-3-DEP-90-7.0

B200.0692

## Option B

**Newborn And Adopted Children** We cover your newborn child for dependent benefits, from the moment of birth. We also cover your adopted child for dependent benefits from the moment of birth if you take physical custody of the child upon such child's release from the hospital and you file a petition for adoption within 30 days of the child's birth.

We do this only if: (a) you are already covered for dependent child coverage when the child is born, adopted or placed for adoption; or (b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born, adopted or placed for adoption. 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.

CGP-3-DEP-90-8.0

B489.0027

## Option B

**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.

If a surviving dependent elects to continue his or her dependent benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan*, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

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



## Dependent Coverage (Cont.)

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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.

An individual dependent's coverage ends when he or she 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 or she marries, when a child covered as a student is no longer an active *full-time* student, or when a step-child is no longer dependent on you 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. But, if a child who is enrolled as a *full-time* student must take a medical leave of absence from school due to sickness, his or her coverage may be continued. Such coverage may be continued for up to one year from the last day the child attended school, but not beyond the date coverage would otherwise end under this *plan* if he or she did not take the medical leave of absence; provided: (a) we receive a *doctor's* certification of the sickness which requires the leave of absence; (b) the group *plan* remains in force; and (c) all required premiums for the child's coverage continue to be paid.

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.

CGP-3-DEP-90-9.0

B509.0345

Option B

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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.

● **PPO 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

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

For Group I Services . . . . . None  
For Group II and III Services . . . . . \$100.00  
for each covered person

CGP-3-DENT-HL-90

B497.0070

Option B

● **Payment Rates for Services Furnished by a Preferred Provider:**

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

● **Payment Rates for Services Not Furnished by a Preferred Provider:**

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

CGP-3-DENT-HL-90

B497.0088

Option B

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

For Group I, II and III Services . . . . . Up to \$1,000.00

**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.

CGP-3-DENT-HL-90

B497.1431

**Option B**

**DentalGuard Preferred Plus** Benefits for services provided by a preferred provider in the plus program ("DentalGuard Preferred Plus Providers") will be reimbursed based on the non-preferred provider (Non-PPO) payment rates, deductibles, benefit year and lifetime payment limits, frequency and age limitations, coverages and exclusions.

CGP-3-DENT-HL-90

B497.2458

**Option B**

**Group Enrollment Period** A group enrollment period is held each year. The group enrollment period is a time period agreed to by your employer and us. During this period, you may elect to enroll in dental insurance under this *plan*. Coverage starts on the first day of the month that next follows the date of enrollment. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

CGP-3-DENT-HLTS

B497.2411

Option B

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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.

CGP-3-DG2000

B498.0007

Option B

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**DentalGuard Preferred - This Plan's Dental Preferred Provider Organization**

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This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO)*, which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider*. Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider*.

But, this *plan's* deductible amounts differ based upon whether a *covered person* uses the services of a *preferred provider* or a *non-preferred provider*. A *covered person* will usually be left with less out-of-pocket expense when a *preferred provider* is used.

When an *employee* enrolls in this *plan*, he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers*.

A *covered person* must present his or her ID card when he or she uses a *preferred provider*. Most *preferred providers* prepare necessary claim forms for the *covered person*, and submit the forms to *us*. We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider*.

What we pay is based on all of the terms of this *plan*. Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits*.

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan*.

CGP-3-DGY2K-PPO

B498.0147

## Option B

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### Covered Charges

If a *covered person* uses the services of a *preferred provider*, covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

If a *covered person* uses the services of a *non-preferred provider*, covered charges are reasonable and customary charges for the dental services listed 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 80th 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. 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.

CGP-3-DGY2K-CC

B498.0067

## Option B

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### Appeals Process

#### External Appeal

<b>Right To An External Appeal</b>	As shown below, the covered person has a right to an external appeal of a denial of coverage. If we denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, the covered person or his or her representative may appeal that decision to an External Appeal Agent. "An External Appeal Agent" means an independent entity certified by the State to conduct such appeals.
<b>Right To Appeal A Determination That A Service Is Not Medically Necessary</b>	If coverage has been denied on the basis that the service is not medically necessary, the covered person may appeal to an External Appeal Agent if he or she satisfies both of the following: <ul data-bbox="488 569 1422 737" style="list-style-type: none"><li>● The service, procedure or treatment must be covered by this plan; and</li><li>● The covered person must have received a final adverse determination through this plan's internal appeal process, and Guardian must have upheld the denial; or the covered person and Guardian must agree in writing to waive any internal appeal.</li></ul>
<b>Right To Appeal A Determination That A Service Is Experimental Or Investigational</b>	If coverage has been denied on the basis that the service is experimental or investigational, he or she must satisfy both of the following: <ul data-bbox="488 856 1422 1024" style="list-style-type: none"><li>● The service must be covered by this plan; and</li><li>● The covered person must have received a final adverse determination through this plan's internal appeal process and Guardian must have upheld the denial; or the covered person and Guardian must agree in writing to waive any internal appeal.</li></ul>
<b>The External Appeal Process</b>	If, through this plan's internal appeal process, the covered person received a final adverse determination that upholds a denial of coverage on the basis that the service is not medically necessary or is experimental or investigational treatment, he or she has 45 days from receipt of such notice to file a written request for an external appeal. If the covered person and Guardian have agreed in writing to waive any internal appeal, he or she has 45 days from receipt of such waiver to file a written request for an external appeal. An external appeal application will be provided with the final adverse determination, or with the written waiver of an internal appeal. <p data-bbox="488 1367 1422 1556">The covered person may also request an external appeal application from New York State at 1-800-400-8882. He or she must complete the application and submit it to the State Department of Insurance at the address shown on the application. If the covered person meets the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.</p> <p data-bbox="488 1577 1422 1827">The covered person will be able to submit added documentation with his or her request. If the External Appeal Agent decides that the information the covered person submits shows a material change from the information on which we based our denial, the External Appeal Agent will share this information with us so that we can exercise our right to reconsider our decision. If we choose to do so, we have three business days to amend or confirm our decision. Please note that in the case of an expedited appeal, described below, we do not have a right to reconsider our decision.</p>

In general, the External Appeal Agent must make a decision within 30 days of receipt of the covered person's completed application. The External Appeal Agent may request more information from the covered person, his or her dentist or us. If the External Appeal Agent requests more information, it will have five more business days to make its decision. The External Appeal Agent must notify the covered person in writing of its decision within two business days.

If the covered person's dentist certifies that a delay in providing a service that has been denied poses an imminent or serious threat to the covered person's health, the covered person may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within three days of receipt of the covered person's completed application. Right after reaching a decision, the External Appeal Agent must try to notify the covered person and Guardian of that decision by telephone or fax. The External Appeal Agent must also notify the covered person of its decision in writing.

If the External Appeal Agent overturns the decision that a service is not medically necessary or approves coverage of an experimental or investigational treatment, we will provide coverage subject to all of the other terms and conditions of this plan. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to the covered person in accord with the design of the trial. And we do not pay for:(a) the cost of investigational drugs or devices; (b) the cost of non-dental care services; (c) the cost of managing research; or (d) costs which would not be covered under this plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the covered person and Guardian. The External Appeal Agent's decision is admissible in court.

We will charge the covered person a fee of \$50.00 for an external appeal. The external appeal application instructs the covered person on how he or she must submit the fee. We will waive the fee if we determine that paying the fee would pose a hardship to the covered person. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to the covered person.

**The Covered Person's Responsibilities** **It is the covered person's RESPONSIBILITY to initiate the external appeal process.** The covered person may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to the covered person, his or her dentist may file an external appeal application on the covered person's behalf, but only if he or she has consented to this in writing.

Under New York State law, the covered person's completed request for appeal must be filed within 45 days of either the date upon which the covered person receives written notification from us that we have upheld a denial of coverage, or the date on which he or she receives a written waiver of any internal appeal. Guardian has no authority to grant an extension of this deadline.

**Covered Services/Exclusions**

In general, this plan does not cover experimental or investigational treatments. However, we will cover an experimental or investigational treatment approved by an External Appeal Agent in accordance with all of the other terms and conditions of this plan. If the External Appeal Agent approves coverage of experimental or investigational treatment that is part of a clinical trial, we will only cover the costs of services required to provide treatment to the covered person according to the design of the trial. We shall not be responsible for: (a) the cost of investigational drugs or devices; (b) the cost of non-dental care services; (c) the cost of managing research; or (d) costs which would not be covered under this plan for non-experimental or non-investigational treatments provided in such clinical trial.

CGP-3-DGY2K-APPL

B498.0381

**Option B**

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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. Failure to furnish such proof within such time will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.

CGP-3-DGY2K-AT-NJ

B498.0313



## Option B

### Pre-Treatment Review

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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*.

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.

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.

CGP-3-DGY2K-PTR

B498.0004

## Option B

### 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.

CGP-3-DGY2K-OS

B498.0005

**Option B**

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**The Benefit Provision - Qualifying For Benefits**

**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.

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.

CGP-3-DGY2K-LE

B498.1995

**Option B**

**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 provided by a *preferred provider*. A *benefit year* deductible of \$100.00 applies to Group II and III services provided by a *non-preferred provider*. Each *covered person* must have covered charges from these service groups which exceed each applicable deductible before we pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Covered charges used to satisfy a *covered person's* Non-PPO deductible are also credited toward his or her PPO deductible. And covered charges used to satisfy a *covered person's* PPO deductible are also credited toward his or her Non-PPO deductible.

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*.

CGP-3-DGY2K-BP

B498.0177

**Option B**

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$1,000.00.

CGP-3-DGY2K-BP

B498.0192

Option B

**The Benefit Provision - Qualifying For Benefits**

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.

CGP-3-DG-ROLL-04-2.1

B498.2041

Option B

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

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 Threshold . . . . . \$500.00
- Reward (if all benefits are for services provided by a preferred provider) . . . . . \$350.00
- Reward (if any benefits are for services provided by a non-preferred provider) . . . . . \$250.00
- Bank Maximum . . . . . \$1,000.00

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:

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

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- 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, 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*.

CGP-3-DG-ROLL-04-2

B498.9137

### Option B

**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*.

CGP-3-DGY2K-FL

B498.0073

**Option B**

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

- Benefits for Group I Services performed by a preferred provider . . . . . 100%
- Benefits for Group I Services performed by a non-preferred provider . . . . . 100%
- Benefits for Group II Services performed by a preferred provider . . . . . 80%
- Benefits for Group II Services performed by a non-preferred provider . . . . . 80%
- Benefits for Group III Services performed by a preferred provider . . . . . 50%
- Benefits for Group III Services performed by a non-preferred provider . . . . . 50%

CGP-3-DGY2K-PR

B498.0078

**Option B**

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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.

CGP-3-DGY2K-END

B498.0234

**Option B**

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**Special Limitations**

**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. For the first twelve months that a covered person is 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.

CGP-3-DGY2K-TL-NY

B498.0380

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**Special Limitations**

**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.

CGP-3-DGY2K-PP

B498.1747

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, or *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (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.
- 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.

## Exclusions (Cont.)

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- 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; that is incidental to or results from a medical condition.
- 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, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are 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. Excluded cosmetic services do not include: (1) reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; (2) reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect; (3) care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; and (4) care or treatment necessary due to congenital disease or anomaly.
- Replacing an existing *appliance* or *dental prosthesis* with any *appliance* or *prosthesis*; unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not 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.
- 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) that are incidental to or result from a medical condition.
- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Workers' 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.



## Exclusions (Cont.)

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- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment.*

CGP-3-DGY2K-EXCH-01-NY

B498.2827

### Option B

## 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 three 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.

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.

CGP-3-DNTL-90-13

B490.0148

### Option B

## 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 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.

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**Group I Preventive Dental Services (Cont.)**  
(Non-Orthodontic)

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.

CGP-3-DNTL-90-14

B498.4803

**Option B**

**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

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.

CGP-3-DNTL-90-14

B498.0164

**Option B**

**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

CGP-3-DNTL-90-14

B498.0165

## Option B

**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.

CGP-3-DNTL-90-14

B498.0166

## Option B

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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.

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

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

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**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.

CGP-3-DNTL-90-15-

B498.2764

**Option B**

**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

**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.

CGP-3-DNTL-90-15

B498.1122

**Option B**

**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

CGP-3-DNTL-90-15.0

B498.0201

## Option B

**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.

CGP-3-DNTL-90-15.0

B498.0202

## Option B

**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.

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

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

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

CGP-3-DNTL-90-15.0

B498.0203

**Option B**

**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

CGP-3-DNTL-90-15.0

B498.1124

**Option B**

**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.

CGP-3-DNTL-90-15

B498.0206



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

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**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

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

(Non-Orthodontic)

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

#### 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

CGP-3-DNTL-90-16

B498.1129

## Option B

**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

CGP-3-DNTL-90-16

B498.1132

**Option B**

**DISCOUNTS - THIS IS NOT INSURANCE**

**Discounts on Services Not Covered Due To Contractual Provisions** If a covered person receives dental services from a dentist who is under contract with Guardian’s DentalGuard Preferred, Preferred Provider Organization (PPO) network, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of the PPO network, even if such services are not covered by the plan due to:

- Meeting the plan’s benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions.

When a person is no longer covered by this plan, access to the network discounts ends.

CGP-3-DISCOUNTS-11

B499.0092

**Option B**

**DISCOUNTS - THIS IS NOT INSURANCE**

**Discounts on Cosmetic Dental Services** If a covered person receives any of the following dental services from a dentist who is under contract with Guardian’s DentalGuard Preferred, Preferred Provider Organization (PPO) network, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of the PPO network.

The services are:

Cosmetic bleaching (external bleaching, per arch; in office or take home).

When a person is no longer covered by this plan, access to the network discounts ends.

CGP-3-DISCOUNTS-11

B499.0093

**Option B**

**DISCOUNTS - This Is Not Insurance**

**Discounts on Dental Services Not Covered By This Plan**

A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

- (a) he or she receives services or supplies from a dentist that is under contract with Guardian's DentalGuard Preferred, Preferred Provider Organization (PPO) network; and
- (b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.

CGP-3-DISCOUNTS-11

B499.0094

**Option B**

**DISCOUNTS - THIS IS NOT INSURANCE**

**Discounts on Orthodontic Services**

If a covered person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred, Preferred Provider Organization (PPO) network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of the PPO network.

The services are:

- Pre-orthodontic treatment visit;
- Limited orthodontic treatment;
- Interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- Comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- Periodic comprehensive orthodontic treatment visit (as part of a contract);
- Orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- Incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- Retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;

- Extractions performed solely to facilitate orthodontic treatment;
- Orthognathic surgery and associated incremental charges;
- Replacement of lost or broken retainers.

When a person is no longer covered by this plan, access to the network discounts ends.

CGP-3-DISCOUNTS-11

B499.0095

## Option B

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### **Discounts on Dental Services Not Covered By This Plan**

A covered person under this plan can receive discounts on cavity fighting products such as Xylitol. The discount is 25%.

The services and supplies are not covered by this plan. The covered person must pay the entire discounted fee directly to the supplier. A claim should not be filed.

When a person is no longer covered by this plan, access to the discounts ends.

CGP-3-SERDIS-07-NY

B499.0083

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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 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:

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.

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.

**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.

**Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment 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) blanket school accident type coverage or such coverages issued to a substantially similar group; or (ii) 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.

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 coverage, if any, provided under this group plan.

CGP-3-R-COB-09-NY

B555.0382

### Option B

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## Order Of Benefit Determination

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.



## Order Of Benefit Determination (Cont.)

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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.

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

- (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.

**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.

## Order Of Benefit Determination (Cont.)

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**Length Of Coverage** If none of the above rules determines the order of benefits, the benefits of the plan which covered the person longer are determined before those of the plan which covered the person for the shorter time. To determine the length of time a person has been covered under a plan, two plans will be treated as one if the person was eligible under the second plan within 24 hours after the first plan ended. Therefore, the start of a new plan does not include: i) a change in the amount or scope of a plan's benefits; ii) a change in the entity which pays, provides or administers the plan's benefits; or iii) a change from one type of plan to another. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If the date is not readily available, the date the person first became a member of the group shall be used to determine the length of time the person's coverage under the present plan has been in force.

**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.

CGP-3-R-COB-09-NY

B555.0383

### Option B

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### Effect On The Benefits Of This Plan

**When This Plan Is Primary** When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan's benefits.

**When This Plan Is Secondary** 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.

In the event a claim is sent to this plan before submission to the primary health insurer this plan will deny the claim and provide the health care provider with the identity of the primary health insurer or if the primary health insurer is not known, whatever information was used to make the determination that this plan is secondary. If this information is not sufficient to determine the identity of the primary insurer the health care provider will have 60 days from the notice that other coverage may exist to make a reasonable effort to confirm such coverage exists. If, after this timeframe, the health care provider is unable to confirm other health care coverage, this plan will determine benefits as if it were primary provided that the health care provider resubmits the claim within 30 days with documentation that other coverage could not be confirmed despite reasonable efforts to do so.

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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.

If this plan determined benefits as if it were primary and subsequently receives information that other coverage exists and that this plan is secondary, this plan will delay any action to recover the payment for 120 days from the date the health care provider is notified that other coverage exists. This plan will provide the health care provider with the identity of the primary health insurer or if the primary health insurer is not known, whatever information was used to make the determination that this plan is secondary. If this information is not sufficient to determine the identity of the primary insurer the health care provider will have 60 days from the notice that other coverage may exist to make a reasonable effort to confirm such coverage exists. If, after this timeframe, the health care provider is unable to confirm other health care coverage, this plan will cease recovery efforts provided that the health care provider submits documentation within 30 days that other coverage could not be confirmed despite reasonable efforts to do so.

CGP-3-R-COB-09-NY

B555.0384

Option B

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**CERTIFICATE AMENDMENT**

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This plan is amended so that if a covered person is injured because of a third party's wrongful act or negligence:

- we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to The Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery;
- we will be subrogated only to the extent of benefits paid by this plan because of that injury; and
- we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider:

"Subrogation" means our right to recover any benefit payments made under this plan:

- because of an injury to a covered person caused by a third party's wrongful act or negligence; and
- which the covered person later recovers from the third party or the third party's insurer.

"Third Party" means any person or organization other than The Guardian, the employer or the covered person.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

**The Guardian** Life Insurance Company of America

*Stuart J Shaw*  
Vice President, Risk Mgt. & Chief Actuary

**Option B**

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**REQUIRED DISCLOSURE STATEMENT**

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**For Group Plan No.:** G -00433322-

The schedule of insurance on page CGP-3-SI of the certificate booklet is a short summary of the health insurance benefits this plan provides. These benefits, including any exclusions and limitations, are fully explained in other parts of the certificate booklet. **READ THE CERTIFICATE BOOKLET WITH CARE.**

As evidenced by your certificate booklet, this plan provides the following health insurance benefits:

B610.0001

**Option B**

Dental Expense Insurance (defined as Dental Insurance by the New York State Insurance Department)

B610.0012

**Option B**

This plan does not provide Basic Hospital Insurance, Basic Medical Insurance, Medicare Supplement Insurance, or Major Medical Insurance, as defined by the New York State Insurance Department.

B610.0016

**Option B**

**Notice** The above statements are not part of the group policy. The group policy alone determines the rights and duties of: (a) the employer to whom this plan is issued; (b) the policyholder (if other than such employer); (c) the Guardian; and (d) any person covered by this plan.

B610.0017

**Option B**

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**GLOSSARY**

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This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118

**Option B**

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

CGP-3-GLOSS-90

B750.0664

**Option B**

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

CGP-3-GLOSS-90

B750.0665

**Option B**

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

CGP-3-GLOSS-90

B750.0666

**Option B**

**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.

CGP-3-GLOSS-90

B750.0667

**Option B**

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

CGP-3-GLOSS-90

B750.0668

**Option B**

**Covered Person** means an employee or any of his or her covered dependents.

CGP-3-GLOSS-90

B750.0669

**Option B**

**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.

CGP-3-GLOSS-90

B750.0670

**Option B**

**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*.

CGP-3-GLOSS-90

B750.0671

**Option B**

**Eligibility Date** for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

CGP-3-GLOSS-90

B900.0003

**Option B**

**Eligible Dependent** is defined in the provision entitled "Dependent Coverage."

CGP-3-GLOSS-90

B750.0015

**Option B**

**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*.

CGP-3-GLOSS-90

B750.0672

**Option B**

**Employee** means a person who works for the *employer* at the *employer's* place of business, and whose income is reported for tax purposes using a W-2 form.

CGP-3-GLOSS-90

B750.0006

**Option B**

**Employer** means WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY .

CGP-3-GLOSS-90

B900.0051

**Option B**

**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.

CGP-3-GLOSS-90

B900.0004

**Option B**

**Full-time** means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90

B750.0229

**Option B**

**Initial Dependents** means those *eligible dependents* you have at the time you first become eligible for *employee* 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*.

CGP-3-GLOSS-90

B900.0006

**Option B**

**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.

CGP-3-GLOSS-90

B750.0673

**Option B**

**Newly Acquired Dependent** means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents*.

CGP-3-GLOSS-90

B900.0008

**Option B**

**Non-Preferred Provider** means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider*.

CGP-3-GLOSS-90

B750.0674

**Option B**

**Orthodontic Treatment** means the movement of one or more teeth by the use of *active appliances*. 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. This *plan* does not pay benefits for *orthodontic treatment*.

CGP-3-GLOSS-90

B750.0685



**Option B**

**Payment Limit** means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

CGP-3-GLOSS-90

B750.0676

**Option B**

**Payment Rate** means the percentage rate that this *plan* pays for covered services.

CGP-3-GLOSS-90

B750.0677

**Option B**

**Posterior Teeth** means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

CGP-3-GLOSS-90

B750.0679

**Option B**

**Plan** means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90

B750.0678

**Option B**

**Preferred Provider** means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

CGP-3-GLOSS-90

B750.0680

**Option B**

**Prior Plan** means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan*. To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

CGP-3-GLOSS-90

B750.0681

**Option B**

**Proof Of Claim** means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

CGP-3-GLOSS-90

B750.0682

**Option B**

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

CGP-3-GLOSS-90

B750.0683



## **Option B**

**The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.**

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## STATEMENT OF ERISA RIGHTS

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As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### Receive Information About Your Plan and Benefits

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

### Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

### Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

## Statement of Erisa Rights (Cont.)

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Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

### **Assistance with Questions**

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### **Qualified Medical Child Support Order**

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.

B800.0094

**Option B**

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**The Guardian's Responsibilities**

B800.0048

**Option B**

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 employee certificates of insurance, and changes to such certificates.

B800.0053

**Option B**

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

B800.0049

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## Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. 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. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

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").

**Definitions** "Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non-urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

**Timing For Initial Benefit Determination** The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

## Group Health Benefits Claims Procedure (Cont.)

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**Urgent Care Claims.** Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

**Pre-Service Claims.** Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

**Post-Service Claims.** Guardian will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.



## Group Health Benefits Claims Procedure (Cont.)

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**Concurrent Care Decisions.** A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided(a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

### **Adverse Benefit Determination**

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

### **Appeal of Adverse Benefit Determinations**

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;

## Group Health Benefits Claims Procedure (Cont.)

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- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

**Urgent Care Claims.** Guardian will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

**Pre-Service Claims.** Guardian will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

**Post-Service Claims.** Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

**Alternative Dispute Options** The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

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## Option B

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### Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* 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.

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**This Booklet Includes All Managed DentalGuard Benefits For Which You Are Eligible.**

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to your Dental HMO such as an enrollment form and for which premium has been received.

**"Please Read This Document Carefully".**

B850.1498

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**CERTIFICATE OF COVERAGE**

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**The Guardian**

7 Hanover Square  
New York, New York 10004  
(888) 618-2016

We, The Guardian, certify that the *employee* 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		

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.

Stuart J Shaw  
Vice President, Risk Mgt. & Chief Actuary

CGP-3-MDG-NY1

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## GENERAL PROVISIONS

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### Definitions

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As used in this certificate of coverage, the terms listed below are defined as follows. These terms are italicized when used in this certificate of coverage. Defined terms are specific to a particular insurance coverage as found within that coverage.

"Employer" means the *employer* who purchased this *plan*.

"Member" means an *employee* or a *dependent* covered by this *plan*.

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

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

"You" and "your" mean an *employee* covered by this *plan*.

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### Limitation of Authority

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No agent is authorized: (a) to alter or amend this *plan*; (b) to waive any conditions or restrictions contained in this *plan*; (c) to extend the time for paying a premium; or (d) to bind The Guardian by making any promise or by giving or receiving any information.

No change in this *plan* shall be valid unless evidenced by: (a) an endorsement or rider to this *plan* signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of The Guardian; or (b) an amendment to this *plan* signed by the *planholder* and by one of the aforesaid officers of The Guardian.

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### Incontestability

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This *plan* will be incontestable after two years from its effective date, except for non-payment of premiums.

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

If this *plan* replaces the group plan of another insurer, we may rescind this *plan* based on misrepresentations made in a signed application for up to two years from this *plan*'s effective date.

## Examination

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We have a right to have a doctor or *dentist* of our choice examine the person for whom a claim is being made under this *plan* as often as may be reasonably necessary. We 'll pay for all such examinations.

CGP-3-MDG-GP

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## MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

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**Enrollment Procedures** *You and your dependents may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your employer; and (b) returning the materials to your employer, who will forward it to Guardian. After that, you and your dependents need only contact the selected and assigned primary care dentist's office to obtain services.*

Guardian will issue *you* and each of your *dependents*, either directly or through the representative of your *employer*, a Managed DentalGuard (MDG) identification (ID) card, listing the *member's* name and the name, address and telephone number of his or her selected *primary care dentist (PCD)*.

**Open Enrollment Period** *If you do not enroll for dental coverage under this plan within 30 days of becoming eligible, you must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every twelve (12) months after this plan starts, or at a time mutually agreed upon by your employer and Guardian.*

Your enrollment is for a minimum of twelve (12) consecutive months while you are eligible through your *employer*. Voluntary termination from this *plan* will only be permitted during the open enrollment period.

If, after initial enrollment, *you* or one of your *dependents* disenroll from the *plan* during an open enrollment period, the *member* may not re-enroll until the open enrollment period which occurs after he or she has been without coverage for one (1) full year.

**When Your Coverage Starts** *Your coverage starts on the date shown on the face page of this booklet if you are enrolled when the plan starts. If you are not enrolled on that date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by Guardian; or (b) at the end of any waiting period your employer may require.*

**When Your Dependent Coverage Starts** *Except as stated below, your dependents will be eligible for coverage on the later of: (a) the day you are eligible for coverage; or (b) the first day of the month following the date on which you acquire such dependent.*

If the *dependent* is a newborn child, his or her coverage begins on the date of birth. If the *dependent* is: (a) an adopted child; (b) a stepchild; or (c) a foster child, coverage begins on the date the child is placed in your home. If a newborn child, adopted child or foster child becomes covered under this *plan*, *you* must complete enrollment materials for that *dependent* within 30 days of the date the child is born, adopted or placed for adoption.

**When Coverage Ends** *Subject to any continuation of coverage privilege which may be available to you, your dependents' coverage under this plan ends when your coverage terminates. A member's coverage also ends on the first to occur of:*

- (1) Upon your failure to pay the required premium in accordance with the provisions of this *plan*, if *you* are required to pay any part of this *plan*.



## Member Eligibility and Termination Provisions (Cont.)

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- (2) The end of the month in which *you* or your *dependents* cease to be eligible for coverage under this *plan*.
- (3) The end of the month in which your *dependent* is no longer a *dependent* as defined in this *plan*.
- (4) The date on which *you* or your *dependent* no longer reside or work in the *service area*.
- (5) The end of the 45 day period in which *you* fail to pay any required *patient charge* for services rendered to *you* or your *dependent*, after advance written notice has been sent to *you* of such failure to pay.
- (6) The date *you* or your *dependent* enters active military duty. But, coverage will not end if the *member's* duty is temporary. "Temporary" means duty of 31 days or less.
- (7) Immediately, if *you* or your *dependent*: (a) have knowingly given false information in writing on an enrollment form; or (b) have misused your ID card or other documents provided to obtain benefits under this *plan*.
- (8) 30 days after written notice is sent to *you* advising that *you* or your *dependent's* coverage will end because *we* have determined that: (a) the *member's* behavior is (i) disruptive; (ii) unruly; (iii) abusive; (iv) unlawful; (v) fraudulent; or (vi) uncooperative to the extent that the *member's* continued participation in the *plan* seriously impairs the *plan's* ability to provide services to either your *employer* or to other *members*; or (b) the *member* is not able to maintain an appropriate dentist-patient relationship.

We will have:

- (a) made a reasonable effort to resolve the problem presented by the *member*, including the use or attempted use of *member* grievance procedures;
- (b) ascertained, to the extent possible, that the *member's* behavior is not related to the use of medical services or medical illness; and
- (c) documented the problems, efforts and medical conditions on which the problem is based.

*Member* termination under items (7) and (8) above is subject to the rights of appeal described in the Grievance Process section of the *plan*.

### **Extension Of Dental Expense Benefits**

If a *member's* coverage ends, *we* extend dental expense benefits for him or her under this *plan* as explained below.

## Member Eligibility and Termination Provisions (Cont.)

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If a *member's* coverage ends for a reason other than failure to pay any required premium, we only extend benefits for a covered service if the procedure is started before the *member's* coverage ended, subject to all applicable *plan* guidelines. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. Orthodontic treatment is started when the teeth are banded. Root canal is started when the pulp chamber is opened.

This extension of benefits ends on the first to occur of: (a) completion of a procedure which was started before the *member's* coverage ended; (b) 30 days after the *member's* coverage ends; or (c) the date the *member* becomes covered under another plan providing coverage for similar dental procedures.

What we cover is based on all the terms of this *plan*.

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## YOUR CONTINUATION RIGHTS

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*You and your dependents may be eligible to retain coverage under this plan during any Continuation of Coverage period or election period, necessary for your employer's compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for members, provided the employer continues to certify the eligibility of the member and the monthly premiums for COBRA coverage for the member continue to be paid by or through the planholder pursuant to this plan.*

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### An Important Notice About Continuation Rights

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The following "Federal Continuation Rights" section may not apply to your employer's plan. You must contact your employer to find out if: (a) your employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to you.

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### Federal Continuation Rights

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**Important Notice** This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies to dental benefits only. In this section, these coverages are referred to as "group dental benefits."

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active, covered employee; or (c) the dependent of an active, covered employee. Except for a child born to or adopted by a covered employee during a period of continuation, any person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

**If Your Group Dental Benefits End** If your group dental benefits end due to termination of employment or reduction of hours, you may elect to continue such benefits for up to 18 months if: (a) you were not terminated due to gross misconduct; (b) you are not covered for benefits from any other group plan at the time your group dental benefits under this plan would otherwise end; and (c) you are not entitled to Medicare.

The Continuation: (a) may cover you and any other qualified continuee; and (b) is subject to "When Continuation Ends."

## Federal Continuation Rights (Cont.)

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<b>Extra Continuation For Disabled Qualified Continuees</b>	<p>If a qualified continuee is determined to be disabled under Title XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to his or her termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.</p> <p>To elect the extra 11 months of continuation, the qualified continuee must give your <i>employer</i> written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; and (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your <i>employer</i> within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."</p> <p>This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends."</p> <p>An additional 50% of the total premium charge also may be required from the qualified continuee by your <i>employer</i> during this extra 11 month continuation period.</p>
<b>If You Die While Insured</b>	<p>If <i>you</i> die while insured, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."</p>
<b>If Your Marriage Ends</b>	<p>If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."</p>
<b>If A Dependent Loses Eligibility</b>	<p>If a <i>dependent's</i> group dental benefits end due to his or her loss of <i>dependent</i> eligibility as defined in this <i>plan</i>, other than your coverage ending, he or she may elect to continue such benefits. However, such <i>dependent</i> must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".</p>
<b>Concurrent Continuations</b>	<p>If a <i>dependent</i> elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) reduction of work hours, the <i>dependent</i> may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the <i>dependent</i> becomes eligible for 36 months of group dental benefits stated above; or (ii) <i>you</i> become entitled to Medicare.</p> <p>The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.</p>
<b>The Qualified Continuee's Responsibilities</b>	<p>A person eligible for continuation under this section must notify your <i>employer</i>, in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of <i>dependent</i> eligibility, as defined in this <i>plan</i>, of a <i>dependent</i>.</p>

## Federal Continuation Rights (Cont.)

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Such notice must be given to your *employer* within 60 days of either of these events.

**Your Employer's Responsibilities** Your *employer* must notify the qualified continuee, in writing, of: (a) his or her right to continue this *plan's* group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer*, in writing, of your legal divorce or legal separation from your spouse, or the loss of *dependent* eligibility of a *dependent*.

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### Option A

**Your Employer's Liability** Your *employer* will be liable for the qualified continuee's continued group dental benefits to the same extent as, and in place of, *us* if: (a) your *employer* fails to remit a qualified continuee's timely premium payment to us on time, thereby causing the qualified continuee's continued group dental benefits to end; or (b) your *employer* fails to notify the qualified continuee of his or her continuation rights, as described above.

**Election Of Continuation** To continue his or her group dental benefits, the qualified continuee must give your *employer* written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's premium in a timely manner.

The subsequent premiums must be paid to your *employer*, by the qualified continuee, in advance, at the times and in the manner specified by your *employer*. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed enrolled in the group *plan* on a regular basis. It includes any amount that would have been paid by your *employer*. Except as explained in the "Extra Continuation for Disabled Qualified Continuees" an additional charge of 2% of the total premium charge may also be required by your *employer*.

If the qualified continuee: (a) fails to give your *employer* notice of his or her intent to continue; or (b) fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace In Payment of Premiums** A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

## Federal Continuation Rights (Cont.)

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- When Continuation Ends** A qualified continuee's continued group dental benefits end on the first of the following:
- (a) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental benefits would otherwise end;
  - (b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that the continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
  - (c) with respect to continuation upon the your death, your legal divorce or legal separation, or the end of a *dependent's* eligibility, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
  - (d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
  - (e) the date the *plan* ends;
  - (f) the end of the period for which the last premium payment is made;
  - (g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or
  - (h) the date he or she becomes entitled to Medicare.

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## DENTAL EXPENSE COVERAGE

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This *plan* will cover many of the dental expenses incurred by you and those of your dependents who are covered for dental benefits under this *plan*. We decide: (a) the requirements for services to be paid; and (b) what benefits are to be paid by this *plan*. We also interpret how this *plan* is to be administered. What we cover and the terms of coverage are explained below. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

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### Managed DentalGuard -This *Plan's* Dental Coverage Organization

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**Managed DentalGuard** This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires members to seek dental care from participating dentists that belong to the MDG network. Except for emergency dental services, in no event will we pay for dental care provided to a member by a non-participating dentist.

The MDG network is made up of participating dentists in a member's geographic area. A "participating dentist" is a *dentist* that has an MDG participation agreement in force with us.

When a member enrolls in this *plan*, he or she will get information about Guardian's current participating general dentists. Each member must select from this list of participating general dentists a primary care *dentist* (PCD) who will be responsible for coordinating all of the member's dental care. After enrollment, a member will receive a MDG ID card. A member must present this ID card when he or she goes to his or her PCD.

All dental services covered by this *plan* must be coordinated by the PCD whom the member selects and is assigned to upon enrolling in this *plan*. What we cover is based on all the terms of this *plan*. Please read this material with care. Read this plan carefully for specific benefit levels, exclusions, coverage limits and patient charges.

You can call our Member Services Department at 1-888-618-2016 if you have any questions after reading this booklet.

**Choice Of Dentists** A member may select any available participating general *dentist* as his or her PCD. A request to change PCDs must be made to us. Any such change will be effective the first day of the month following approval. We may require up to 30 days to process and approve any such request. All fees and patient charges due to the member's current PCD must be paid in full prior to such transfer.

## **Managed DentalGuard -This *Plan's* Dental Coverage Organization (Cont.)**

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We compensate our participating general dentists through an advance payment agreement by which they are paid a fixed amount of money each month based upon the number of members that select them as their PCD. In addition, we may make supplemental payments on a limited number of specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the participating general *dentist* receives from us. The dentists also receive compensation from *plan* members who may pay an office visit charge for each office visit and a defined patient charge for specific dental services. The schedule of patient charges is shown in the Covered Dental Services And Patient Charges section of this booklet.

### **Continuity Of Care For New Members**

If a newly enrolled member is in an ongoing course of treatment with a non-participating dentist; and the member has a life-threatening disease or condition; or the member has a degenerative or disabling condition; and the member elects to continue care from his or her current *dentist*, we will authorize such care for up to 60 days. But, the current *dentist* must agree:

- i) to be reimbursed at contracted rates and payment of any patient charge which may apply, as payment in full;
- ii) to adhere to our quality assurance requirements;
- iii) to provide necessary medical information related to such care; and
- iv) to otherwise adhere to our policies and procedures.

The above policies and procedures include, but are not limited to: (a) pre-authorization of referrals; and (b) offering the member a treatment plan approved by us.

We will not provide benefits for any service or procedure which, subject to applicable plan guidelines; (a) is not a covered service under this *plan*; or (b) is in excess of the limits specified in the "Limitations" section of this booklet.

### **Changes In Dentist Participation**

If: (a) the *dentist* you have selected is no longer a participating *dentist* in the MDG network; or (b) if we take an administrative action which impacts the dentist's participation in the network, we may have to assign you to a different participating *dentist*. In the event that this occurs, you will have the opportunity to choose another participating *dentist* from among those in the MDG network. If you have a dental procedure in progress when reassignment becomes necessary, we will, at your option and subject to applicable law, either: (a) arrange for completion of the services by the original participating *dentist*, if he or she agrees: (i) to accept payment at the contracted rate; and (ii) to abide by all *plan* provisions; or (b) make reasonable and appropriate arrangements for another participating *dentist* to complete the service. We will send you written notice when we are aware that a participating *dentist* is no longer available to treat you. This will be done within fifteen (15) days from the date we become aware that he or she will no longer be available.

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## Option A

**Specialty Referrals** A member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a participating specialist. We will pay for covered services for specialty care, less any applicable patient charges, when such specialty services are provided in accordance with the specialty referral process described below.

We compensate our participating specialists the difference between their contracted fee and the patient charge shown in the Covered Dental Services And Patient Charges section. This is the only form of compensation that participating specialists receive from us.

ALL SPECIALTY REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY GUARDIAN; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty services to be covered by this *plan*, the following referral process must be followed:

- (1) A member's PCD must coordinate all dental care.
- (2) When the care of a participating specialist is required, the member's PCD must contact us and request authorization.
- (3) If the PCD's request for specialist referral is approved, we will notify the member. He or she will be instructed to contact the participating specialist to schedule an appointment.
- (4) If the PCD's request for specialist referral is denied, the PCD and the member will be notified of the reason for the denial. Referrals may be denied because:
  - (a) The service requested is within the scope of the PCD's responsibility. This is called "denial of access to a referral". Please see the "Grievance Process" in this booklet;
  - (b) The service requested is not a covered service under the *plan*. Such service is either excluded or limited under this *plan*. Please see the "Grievance Process" in this booklet; or
  - (c) The dental service is determined to be not medically necessary. "Medically Necessary Services" means covered dental services which are: (i) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (ii) consistent with nationally accepted standards of practice. Please see the "Utilization Review and Utilization Review Appeal Process" in this booklet.
- (5) A member who receives authorized specialty services must pay all applicable patient charges associated with the services provided.

## Managed DentalGuard - This Plan's Dental Coverage Organization (Cont.)

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When we authorize specialty dental care, a member will be referred to a participating specialist for treatment. The MDG network includes participating specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the member's service area. If there is no participating specialist in the member's service area, we will refer the member to a non-participating specialist of our choice. Except for emergency dental services, in no event will we cover dental care provided to a member by a specialist not pre-authorized by us to provide such services.

A member is entitled to a "standing referral" to a participating specialist and/or, if applicable, a specialty care center under the following conditions:

- (a) upon diagnosis of a life-threatening condition or disease; or
- (b) a degenerative or disabling condition or disease requiring specialized care over a prolonged period.

In all other cases, all specialty referral services must be pre-authorized by us, as stated above.

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### Option A

**Emergency Dental Services** We provide for *emergency dental services* twenty-four hours a day, seven days a week, to all *members*. A *member* should contact his or her selected and assigned *PCD*, who will make arrangements for such care. If a *member* is unable to reach his or her *PCD* in an emergency during normal business hours, he or she must call *our* Member Services Department for instructions. If a *member* is unable to reach his or her *PCD* in an emergency after normal business hours, the *member* may seek *emergency dental services* from any *dentist*. Then, within 2 business days, the *member* should call Guardian to advise of the emergency claim. The *member* must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her *PCD*. This must be done within 90 days, or as soon as is reasonably possible. We will reimburse the *member* for the cost of the *emergency dental services*, less any *patient charge* which may apply.

**Out-Of-Area Emergency Dental Services** If a *member* is more than 50 miles from his or her home and *emergency dental services* are required, he or she should seek care from a *dentist*. Then he or she must file a claim within 90 days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating *dentist*. The statement must list all services provided. We will reimburse the *member* within 30 days for any covered *emergency dental services*, up to a maximum of \$50.00 per incident, after payment of any *patient charge* which may apply.

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## Grievance Process

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**Overview** *Member* grievances are handled by Guardian's Quality of Care Liaison (QCL) or a person named by him or her. This is done under the supervision of the Dental Director or a person named by him or her. The process is designed to quickly and satisfactorily address *member* concerns. A grievance may be submitted by: (a) a *member*; (b) a person acting on behalf of a *member*; or (c) a *member's dentist*.

A *member* may file a grievance regarding an administrative or a health care concern. A *member* may also use a grievance to seek a reversal of a denial of access to a specialist's care for certain services, or a determination that a procedure or service is not a covered service under the *Plan*. A grievance should not be used to seek a reversal of an adverse Utilization Review determination. An adverse determination is made when the services described in a specialty referral request are found to be not medically necessary.

**Process** Requests for specialty referrals will be reviewed according to *plan* guidelines (See the Specialty Referral section under the heading "Dental Expense Coverage" in this booklet). The *member* and his or her *dentist* will be informed of any denial. This will include, but will not be limited to: (a) access to a referral; or (b) determination that a service or procedure is not a covered service under the *plan*. The *member* or *dentist* may request a re-evaluation of the decision according to the procedures outlined below:

- (1) Questions or concerns may be directed to *us* either by telephone or mail. The *Member Services* Department may be reached at 1-888-618-2016 between 9:30 a.m. and 7:30 p.m., Eastern Time, or by mail to P.O. Box 4391, Woodland Hills, CA 91367. A *member* may leave a message on *our* after hours answering machine. *We* will call back no less than one business day after the call was recorded. The *Member Services* Department includes employees with diverse language ability in order to help *members* who do not speak English. When *member* issues or concerns are received by telephone, the *Member Services* Representative documents the call and works with the *member* to resolve the issue. If the *member* wishes to document the grievance in writing, the *Member Services* Representative sends the *member* a grievance form to complete. If the *member* wishes to submit an oral grievance, the *Member Services* Representative completes the grievance form for him or her. It is mailed to the *member* within 5 business days. The grievance form has prominent instructions which state that the *member* must sign and return the grievance form to the QCL with any amendments, in order to start the grievance resolution process. All written *member* issues are documented and reviewed. The *member*: (a) has the right to name a person to act on his or her behalf to file the grievance; and (b) must inform Guardian in writing of the name of the person acting on his or her behalf at the time the grievance form is submitted.
- (2) Within 15 business days after the receipt of the written grievance, an acknowledgement letter is sent to the *member* indicating that a review is taking place. The letter will state the name, address and telephone number of the QCL.

## Grievance Process (Cont.)

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- (3) Under the supervision of the QCL, supporting documentation is collected. The dental office may be asked to provide copies of relevant dental records and radiographs, if applicable.
- (4) Upon receipt of complete documentation, the grievance is reviewed and a determination is made.
  - a. Determinations of denial of access to a referral will be made by a *dentist* reviewer.
  - b. Determinations that a procedure is not a covered service under this *plan* may be made by qualified personnel.

**Expedited Grievances** Grievances which involve an emergency: (a) are those which possess a significant risk to the *member's* health; and (b) will be concluded in accordance with the denial of immediacy of the case.

We define emergency dental services as bona fide emergency services which are reasonably necessary: (a) to relieve the sudden onset of severe pain, swelling, serious bleeding or severe discomfort; or (b) to prevent the imminent loss of teeth, and are *covered services* under this *plan*.

On receipt of complete documentation, the expedited grievance is reviewed and a determination is made.

- a. Determinations of denial of access to a referral will be made by a *dentist* reviewer.
- b. Determinations that a procedure is not a *covered service* under this *plan* may be made by qualified personnel.

**Timeframes** Timeframes for resolution of grievances are as follows:

**Emergency Grievances:** Within 48 hours from receipt of all necessary information for expedited emergency cases, with written notice to follow within 2 business days.

**Prospective Grievances:** Within 30 days from receipt of all necessary information for: (a) issues involving requests for referrals; or (b) determinations concerning whether a service or procedure is a covered service under the *plan*.

**Retrospective Grievances:** Within 45 days from receipt of all necessary information in all other cases.

**Notification** The notice of a determination of a grievance appeal will include:

- a. the detailed reasons for the determination; and
- b. in cases where the determination has a clinical basis, the clinical rationale for the determination.

## Option A

**Grievance Appeals Process** If the *member* is not satisfied with the grievance resolution, he or she may file a written or telephone grievance appeal within 60 business days of receipt of the grievance resolution.

**Standard Grievance Appeals** which involve prospective or retrospective treatment will be acknowledged by *us* within 15 days of receipt. The acknowledgement will include: (a) the name, address and phone number of the person(s) responsible for resolution; and (b) notice of needed additional information, if any, to resolve the grievance appeal.

**Expedited Grievance Appeals** which involve an emergency: (a) are those that pose a significant risk to the *member's* health; and (b) will be resolved within 48 hours of receipt of all necessary information.

The determination of a grievance appeal on a clinical matter will be made by a different *dentist* reviewer than the one involved in the initial grievance resolution. The determination of a non-clinical matter will be resolved by qualified personnel at a higher level than the personnel who made the initial grievance determination.

Following the resolution of the grievance appeal, the *member* and Guardian each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by the *dentist*.

CGP-3-MDG-GRV-NY

B850.0575

## Option A

**Files** Each grievance and grievance appeal will be kept on file in *our* Woodland Hills, California office. Grievance files will contain:

- a. the *member's* name and social security number;
- b. the date the grievance was filed;
- c. a copy of the grievance;
- d. the date of *our* receipt of, and a copy of, the *member's* grievance form of the oral grievance which began the grievance process;
- e. a copy of and the date of the grievance determination;
- f. the title and, for a clinical determination, the credentials of the *general* or *specialist dentist* who reviewed the grievance or the grievance appeal, if applicable; and
- g. a copy of the grievance appeal, if applicable.

**Written Notice Of Grievance Process** We will give a *member* written notice of this *plan's* grievance process at any time that *we* deny: (a) access to a specialty referral; or (b) benefits for a service which is not a covered service under this *plan*.

CGP-3-MDG-GRVNY2

B850.0571

## **Utilization Review and Utilization Review Appeal Process**

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**Definitions** "Utilization Review (UR)" means the review of specialty referrals to determine whether dental services are medically necessary. UR does not include: (a) denial of access to a specialty referral, unless the referral is denied for reasons of medical necessity; or (b) a determination that a procedure or service is not a covered service under the *plan*.

"Utilization Review Appeal (URA)" means an appeal of an adverse determination concerning the medical necessity of dental services.

"Adverse Determination (AD)" means a determination by a *general* or *specialist dentist* reviewer, as appropriate, that a dental service is not medically necessary.

"Medically Necessary Services" means covered dental services which are: (a) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (b) consistent with nationally accepted standards of practice.

**Overview** Determinations in Utilization Review and the Utilization Review Appeals Process are reviewed by a *general* or *specialist dentist* reviewer, as appropriate. This is done under the supervision of the Dental Director or a person named by him or her. The process is designed to quickly and satisfactorily address *member* concerns. A concern may be submitted by: (a) a *member*; (b) a person acting on behalf of a *member*; or, only in the case of a retrospective AD, (c) a *member's dentist*.

**Policies And Procedures** We perform UR on specialty referral services. When preparing a *member's* treatment plan, a *PCD* may identify the need for more complex treatment which requires the skills of a specialist. All referrals to a specialist must be consistent with a treatment plan that has been communicated to the *member*. The *PCD* must submit a Specialty Referral Form to *us* for: (a) pre-authorization of all non-emergency treatment; and (b) approval of referral of a *member* to a specialist. This process allows *us* to monitor the frequency and appropriateness of the requested treatment. We have established Specialty Referral Guidelines for *participating dentists*. These guidelines include procedures for authorization and payment of specialty referrals.

Specialty referrals which may be denied for medical necessity will follow the process described below.

We do not require pre-authorization of *PCD* services. However, if a *PCD* or a *member* requests pre-authorization of a *PCD* service, and the service is denied for medical necessity, the process set forth for appealing specialty referrals will apply.

**Process** Services which may be denied for medical necessity are to be handled by a *general* or *specialist dentist* reviewer, as appropriate. The *member* or his or her *dentist* may contact the QCL at 1-888-618-2016 between 9:30 a.m. and 7:30 p.m., Eastern Time, or by mail to P.O. Box 4391, Woodland Hills, CA 91367 to request a URA.

**Time Frames For UR Determinations** A. **Prospective Determinations**

## Utilization Review and Utilization Review Appeal Process (Cont.)

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**Standard:** All proposed specialty referrals are to be evaluated. *We* will inform the *dentist* and the *member* of the result of the review by telephone and in writing. This will be done within 3 business days from the receipt of all necessary documentation.

**Expedited:** All proposed specialty referrals are to be evaluated. *We* will inform the *dentist* and the *member* of the result of the review by telephone and in writing. This will be done within 2 business days from the receipt of all necessary documentation.

**B. Concurrent Determinations:** *We* will inform the *dentist* and the *member* of determinations of medical necessity of specialty referrals which involve continued or on-going treatment by telephone and in writing. This will be done within one business day from receipt of all necessary documentation. Notification of continued or extended services will include: (a) the number of extended services approved; (b) the new total of approved services; (c) the date of onset of services; and (d) the next review date.

**C. Retrospective Determinations:** *We* may require a retrospective review if services authorized in advance are not performed as originally authorized. *We* will inform the *dentist* and the *member* of the determination of the medical necessity of a specialty referral which involves retrospective review in writing. This will be done within 30 days of receipt of all necessary documentation.

**Notification of UR Determinations** *We* will inform the *member* and the *dentist* by telephone and in writing of an AD. Written notice of an AD will:

1. state the reasons for the denial, including the clinical rationale;
2. include the URA process and appeal rights, including the *member's* right to an external appeal;
3. indicate that the review criteria are available upon request; and
4. indicate what additional necessary information must be provided in order to render a decision on appeal.

**Reconsideration Process** If there was no telephone discussion at the time of the initial AD, a telephone discussion will take place between the *member's dentist* and the *dentist* reviewer who made the AD. If the *dentist* reviewer who made the AD is not available, a different *dentist* will be available for the telephone discussion. Additional information may be provided or requested.

**Prospective and Concurrent Reconsiderations** will take place within one business day of receipt of the request and of all necessary documentation.

**Retrospective Reconsiderations** will take place within 30 days of receipt of the request and of all necessary documentation.

Reconsiderations that are denied may be further appealed through the Plan's standard appeal process.

CGP-3-MDG-UR-NY

B850.0572

## Option A

**URA Process** If a *member* or *dentist* has utilized the Reconsideration Process and is still dissatisfied with the outcome, the *dentist* or *member* may: (a) request that an initial AD or reconsideration be further re-evaluated (i.e., a URA); and (b) submit additional information for the re-evaluation. The Standard and Expedited URA Review will be reviewed by a *dentist* reviewer other than the original *dentist* reviewer.

**Standard Process** URAs may be received by telephone or in writing. The *member* or his or her *dentist* may file an appeal with the *plan* within 45 days from the date of the initial review determination and receipt of all necessary information to file an appeal. The *dentist* reviewer will acknowledge the appeal in writing. He or she will include: (a) the name, address and telephone number of the person named by the *plan* to respond to the appeal; and (b) a request for any additional necessary information which must be provided in order to render a decision. This will be done within 15 days of receipt of the appeal. A determination will be made within 60 days of receipt of all necessary information. The *dentist* and/or *member* will be notified of the determination of the appeal within 2 business days of the decision. The reasons for the determination will be included. If the AD is upheld on appeal, the notice will also include the clinical rationale for such determination, as well as the notice of the *member's* right to an external appeal.

CGP-3-MDG-UR-NY

B850.0573

## Option A

**Expedited Process** Expedited URAs may be received by telephone or in writing. The expedited appeal process may be used for: (a) continued or extended dental care services; or (b) an AD when the *member's dentist* believes an immediate appeal is warranted. Expedited appeals are not used for retrospective ADs. Within one business day of receipt of the notice of appeal, the *member* or *dentist* will have reasonable access to the *dentist* reviewer to make it easier to submit any added information in support of the appeal. Determination will be made within 2 business days of receipt of necessary information. Expedited appeals that are denied may be further appealed through the *plan's* standard appeal process. *Members* may also have the right to request an external appeal, as described in the following section.

**External Appeal** *You* and/or your *dentist* have the right to external appeal of a final adverse determination after exhausting our internal review processes. *You* or your *dentist* may request an external appeal of a final AD by our internal appeal process, when:



## Utilization Review and Utilization Review Appeal Process (Cont.)

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- (1) A procedure that would otherwise be a covered service under the *plan* is denied on appeal, in whole or in part, on the grounds that such procedure is not medically necessary; and (a) Guardian has rendered a final AD with respect to such procedures; or (b) both *you* and Guardian have jointly agreed to waive any internal appeal; or
- (2) Coverage of a procedure was denied on the basis that such procedure is experimental or investigational, and such denial has been upheld on appeal; or your *dentist* has certified that *you* have a life-threatening or disabling condition or disease:
  - i) for which standard dental services or procedures have been ineffective or would be medically inappropriate; or
  - ii) for which there does not exist a more beneficial standard dental service or procedure covered by the *plan*; or
  - iii) for which there exists a clinical trial; andYour *dentist* must have recommended either:
  - i) a dental treatment, based on two documents from the available dental and scientific evidence, is likely to be more beneficial to *you* than any covered, standard dental procedure; or
  - ii) a clinical trial for which *you* are eligible.

An external appeal must be initiated in writing within 45 days after the *member* receives notification of the final adverse determination. The notification letter will include instructions for initiating an external appeal.

Any *dentist* certification provided under this section will include a statement of the evidence relied upon by the *dentist* in certifying his or her recommendation. And the specific dental procedure recommended by the *dentist* would otherwise be covered under the *plan* except for Guardian's determination that the dental procedure is experimental or investigational.

Guardian may charge *you* a fee of up to \$50 per external appeal. This fee is refundable to *you* in the event the external appeal agent overturns Guardian's final adverse determination. Guardian will not require *you* to pay any such fee if such fee will pose a hardship to *you*, as determined by Guardian.

Following the decisions of the *dentist* reviewer, *you* and Guardian each have the right to use the legal system for any claim involving the professional treatment performed by a *participating dentist* after the *plan's* internal and external review processes have been exhausted.

CGP-3-MDG-UR-NY2

B850.0574

Option A

**Covered Dental Services And Patient Charges - Schedule 3NYM**

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *member's PCD*.

The *member* must pay the listed *patient charge*. Guardian covers the rest of the *participating dentist's* charge for the service. The benefits we provide are subject to all of the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions.

These *patient charges* are only valid for covered services rendered by *participating dentists* in the State of New York.

MDG Codes+	Description of Service	Patient Charge
<b>Appointments and Diagnostic Services</b>		
	0101 Office Visit - during regular hours - participating general dentist only . .	\$5.00
	0102 Broken Appointment (without 24 hours notice) . . . . .	\$20.00
0120, 0140,	0150 Oral evaluation . . . . .	No Charge
	0460 Pulp vitality tests . . . . .	No Charge
	0470 Diagnostic casts . . . . .	No Charge
	9310 Consultation (by dentist other than practitioner providing treatment) . . . . .	\$30.00
	9430 Office visit for observation - regular hours - no other service performed . . . . .	No Charge
	9440 Emergency office visit - after regularly scheduled office hours . . . . .	\$20.00
<b>Radiographs</b>		
	0210 Intraoral - complete series (including bitewings) . . . . .	No Charge
0220, 0230,	0240 Intraoral - periapical or occlusal - single film . . . . .	No Charge
0270, 0272,	0274 Bitewings . . . . .	No Charge
	0330 Panoramic film . . . . .	No Charge
<b>Preventive Services &amp; Space Maintenance</b>		
1110, 1120	Prophylaxis . . . . .	No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child . .	No Charge
	1310 Nutritional instruction for control of dental diseases . . . . .	No Charge
	1330 Oral hygiene instruction . . . . .	No Charge
	1351 Sealant - per tooth . . . . .	\$8.00
	1510 Space maintainer - fixed - unilateral . . . . .	\$54.00
	1515 Space maintainer - fixed - bilateral . . . . .	\$72.00
	1550 Recementation of space maintainer . . . . .	\$12.00
<b>Restorative</b>		
	2110 Amalgam - one surface - primary . . . . .	\$15.00
	2120 Amalgam - two surfaces - primary . . . . .	\$19.00
	2130 Amalgam - three surfaces - primary . . . . .	\$23.00
	2131 Amalgam - four or more surfaces - primary . . . . .	\$28.00

## Covered Dental Services And Patient Charges - Schedule 3NYM (Cont.)

<b>2140</b>	Amalgam - one surface - permanent . . . . .	\$17.00
<b>2150</b>	Amalgam - two surfaces - permanent . . . . .	\$22.00
<b>2160</b>	Amalgam - three surfaces - permanent . . . . .	\$26.00
<b>2161</b>	Amalgam - four or more surfaces - permanent . . . . .	\$32.00
<b>2210</b>	Silicate cement - per restoration . . . . .	\$15.00
<b>2330</b>	Resin/composite - one surface, anterior . . . . .	\$20.00
<b>2331</b>	Resin/composite - two surfaces, anterior . . . . .	\$26.00
<b>2332</b>	Resin/composite - three surfaces, anterior . . . . .	\$32.00
<b>2335</b>	Resin/composite - four or more surfaces or incisal angle, anterior . . .	\$38.00
<b>2336</b>	Composite resin crown, anterior - primary . . . . .	\$95.00
<b>2380</b>	Resin/composite - one surface, posterior - primary . . . . .	\$55.00
<b>2381</b>	Resin/composite - two surfaces, posterior - primary . . . . .	\$65.00
<b>2382</b>	Resin/composite - three or more surfaces, posterior - primary . . . . .	\$80.00
<b>2385</b>	Resin/composite - one surface, posterior - permanent . . . . .	\$56.00
<b>2386</b>	Resin/composite - two surfaces, posterior - permanent . . . . .	\$75.00
<b>2387</b>	Resin/composite - three or more surfaces, posterior - permanent . . .	\$95.00

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

\* If high noble metal is used, there will be an additional charge for the actual cost of the high noble metal used.

CGP-3-MDG-L1-FCW

B850.0576

### Option A

#### Crown, Bridge & Other Cast Restorations

<b>2510</b>	Inlay - metallic - one surface* . . . . .	\$280.00
<b>2520, 6520</b>	Inlay - metallic - two surfaces* . . . . .	\$320.00
<b>2530, 6530</b>	Inlay - metallic - three or more surfaces* . . . . .	\$370.00
<b>2543, 6543</b>	Onlay - metallic - three surfaces* . . . . .	\$380.00
<b>2544, 6544</b>	Onlay - metallic - four or more surfaces* . . . . .	\$395.00
<b>2702</b>	Crown supporting existing partial denture - in addition to crown . . . . .	\$125.00
<b>2703</b>	Multiple crown and bridge unit treatment plan - per unit . . . . .	\$125.00
<b>2740</b>	Crown - porcelain/ceramic substrate . . . . .	\$395.00
<b>2750, 2751, 2752</b>	Crown - porcelain fused to metal* . . . . .	\$395.00
<b>2790, 2791, 2792</b>	Crown - full cast metal* . . . . .	\$395.00
<b>2810, 6780</b>	Crown - 3/4 cast metallic* . . . . .	\$395.00
<b>6210, 6211, 6212</b>	Pontic - cast metal* . . . . .	\$385.00
<b>6240, 6241, 6242</b>	Pontic - porcelain fused to metal* . . . . .	\$385.00
<b>6750, 6751, 6752</b>	Crown - abutment - porcelain fused to metal* . . . . .	\$395.00
<b>6790, 6791, 6792</b>	Crown - abutment - full cast metal* . . . . .	\$395.00

#### Other Restorative Services

<b>2910, 2920, 6930</b>	Recementation inlay, crown, bridge . . . . .	\$18.00
<b>2930, 2931</b>	Prefabricated stainless steel crown . . . . .	\$110.00
<b>2932</b>	Prefabricated resin crown . . . . .	\$135.00
<b>2940</b>	Sedative filling . . . . .	\$17.00
<b>2950, 6973</b>	Core buildup, including any pins . . . . .	\$100.00
<b>2951</b>	Pin retention - per tooth, in addition to restoration . . . . .	\$22.00
<b>2952, 6970</b>	Cast post & core . . . . .	\$155.00
<b>2954, 6972</b>	Prefabricated post & core . . . . .	\$125.00
<b>2960</b>	Labial veneer (laminare) - chairside . . . . .	\$295.00

## Covered Dental Services And Patient Charges - Schedule 3NYM (Cont.)

### Endodontics

<b>3110, 3120</b>	Pulp cap . . . . .	\$10.00
<b>3220</b>	Therapeutic pulpotomy . . . . .	\$25.00
<b>3310</b>	Root canal - anterior . . . . .	\$120.00
<b>3320</b>	Root canal - bicuspid . . . . .	\$145.00
<b>3330</b>	Root canal - molar . . . . .	\$370.00
<b>3346</b>	Root canal - retreatment - anterior . . . . .	\$315.00
<b>3347</b>	Root canal - retreatment - bicuspid . . . . .	\$370.00
<b>3348</b>	Root canal - retreatment - molar . . . . .	\$445.00
<b>3410</b>	Apicoectomy/periradicular surgery - anterior . . . . .	\$265.00
<b>3421</b>	Apicoectomy/periradicular surgery - bicuspid - first root . . . . .	\$300.00
<b>3425</b>	Apicoectomy/periradicular surgery - molar - first root . . . . .	\$350.00
<b>3426</b>	Apicoectomy/periradicular surgery - each additional root . . . . .	\$110.00
<b>3430</b>	Retrograde filling - per root . . . . .	\$80.00

### Periodontics

<b>4210</b>	Gingivectomy or gingivoplasty - per quadrant . . . . .	\$235.00
<b>4211</b>	Gingivectomy or gingivoplasty - per tooth . . . . .	\$60.00
<b>4240</b>	Gingival flap procedure - including root planing - per quadrant . . . . .	\$275.00
<b>4249</b>	Clinical crown lengthening - hard tissue . . . . .	\$275.00
<b>4260</b>	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth . . . . .	\$392.00
<b>4261</b>	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth . . . . .	\$235.00
<b>4270</b>	Pedicle soft tissue graft procedure . . . . .	\$290.00
<b>4271</b>	Free soft tissue graft procedure (including donor site surgery) . . . . .	\$298.00
<b>4341</b>	Periodontal scaling & root planing - per quadrant . . . . .	\$40.00
<b>4355</b>	Full mouth debridement to enable evaluation and diagnosis . . . . .	\$24.00
<b>4910</b>	Periodontal maintenance procedures (following active therapy) . . . . .	\$22.00
<b>4920</b>	Unscheduled dressing change (by other than treating dentist) . . . . .	\$19.00
<b>9951</b>	Occlusal adjustment - limited - per visit . . . . .	\$20.00

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

\* If high noble metal is used, there will be an additional charge for the actual cost of the high noble metal used.

CGP-3-MDG-L2-FCW

B850.0579

### Option A

#### Prosthodontics (Removable)

<b>5110, 5120</b>	Complete denture (including routine post delivery care) . . . . .	\$452.00
<b>5130, 5140</b>	Immediate denture (including routine post delivery care) . . . . .	\$492.00
Partial dentures (including routine post delivery care):		
<b>5211</b>	Upper partial, resin base - including clasps, rests, teeth . . . . .	\$381.00
<b>5212</b>	Lower partial, resin base - including clasps, rests, teeth . . . . .	\$443.00
<b>5213, 5214</b>	Cast metal framework with resin base - including clasps, rests, teeth . . . . .	\$500.00

Repairs and adjustments:

## Covered Dental Services And Patient Charges - Schedule 3NYM (Cont.)

5410, 5411, 5421, 5422 5510 5520, 5640 5610 5630 5650 5660 5710, 5711, 5720, 5721 5730, 5731, 5740, 5741 5750, 5751, 5760, 5761 5820, 5821 5850, 5851	Denture adjustments . . . . . Repair broken denture base . . . . . Replace missing or broken teeth -per tooth . . . . . Repair resin denture base . . . . . Repair or replace clasp . . . . . Add tooth to existing partial . . . . . Add clasp to existing partial . . . . . Rebase denture . . . . . Reline denture (chairside) . . . . . Reline denture (laboratory) . . . . . Interim partial denture (stayplate) . . . . . Tissue conditioning . . . . .	\$25.00 \$50.00 \$45.00 \$55.00 \$70.00 \$65.00 \$80.00 \$200.00 \$110.00 \$150.00 \$175.00 \$45.00
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### Oral Surgery

7110, 7120 7130 7210 7220 7230 7240 7241 7250 7270 7280 7281 7285 7286 7310 7320 7450 7451 7510 7960	Extraction - single tooth . . . . . Root removal - exposed roots . . . . . Surgical removal of erupted tooth . . . . . Removal of impacted tooth - soft tissue . . . . . Removal of impacted tooth - partially bony . . . . . Removal of impacted tooth - completely bony . . . . . Removal of impacted tooth - completely bony, with unusual surgical complications . . . . . Surgical removal of residual tooth roots (cutting procedure) . . . . . Tooth reimplantation and/or stabilization of accidentally evulsed tooth . . . . . Surgical exposure of impacted or unerupted tooth for orthodontic reasons . . . . . Surgical exposure of impacted or unerupted tooth to aid eruption . . . . . Biopsy of oral tissue - hard . . . . . Biopsy of oral tissue - soft . . . . . Alveoplasty in conjunction with extractions - per quadrant . . . . . Alveoplasty not in conjunction with extractions - per quadrant . . . . . Removal of odontogenic cyst/tumor - up to 1.25 cm . . . . . Removal of odontogenic cyst/tumor - over 1.25 cm . . . . . Incision & drainage of intraoral abscess . . . . . Frenulectomy (separate procedure) . . . . .	\$22.00 \$30.00 \$90.00 \$115.00 \$150.00 \$180.00 \$225.00 \$95.00 \$210.00 \$230.00 \$195.00 \$125.00 \$85.00 \$105.00 \$140.00 \$350.00 \$540.00 \$105.00 \$230.00
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### Miscellaneous Services

9110 9215	Palliative (emergency) treatment - per visit . . . . . Local anesthesia . . . . .	\$20.00 No Charge
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+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

\* If high noble metal is used, there will be an additional charge for the actual cost of the high noble metal used.

**Option A**

MDG CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
<b>Orthodontic Services</b>		
8601	Orthodontic evaluation and consultation . . . . .	\$100.00
8602	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos . . . . .	\$150.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: <i>dependent</i> child to age 18 (as determined by the <i>member's</i> age on the date of banding) . . . . .	\$2425.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: <i>employee</i> , spouse or <i>dependent</i> child over age 18 (as determined by the <i>member's</i> age on the date of banding) . . . . .	\$2425.00
8670	Periodic comprehensive orthodontic treatment visit . . . . .	No Charge
8680	Orthodontic retention . . . . .	\$425.00

+ Covered Services are subject to this *plan's* exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

\* These orthodontic *patient charges* are valid only for authorized services rendered by *participating orthodontists* in the State of New York.

CGP-3-MDG-L4-NYA-FCW

B850.0585

**Option A**

**Additional Conditions On Covered Services**

**General Guidelines For Alternative Procedures** More than one procedure may be appropriate for treating a dental condition. A *member* may choose an appropriate alternative procedure over the service recommended by the PCD. If the alternative procedure is covered under the plan, the *member* pays the patient charge for that procedure. If the alternative procedure is not covered under the plan, the PCD may charge his or her usual and customary fee for the non-covered service.

Whenever there is more than once course of treatment available, a full disclosure of all the options must be given to the member before treatment begins. The PCD should present the *member* with a treatment plan in writing before treatment begins, to assure that there is no confusion over what the member must pay.

**Crowns, Bridges And Dentures** The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan*.

The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by reline, rebase or repair. Construction of new dentures may not exceed one new denture in any 5 year period from the date of previous placement under the *plan*.

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for six months; and (b) does not include required future rebasing or relining procedures or a complete new denture.

## Additional Conditions On Covered Services (Cont.)

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- Multiple Crown/Bridge Unit Treatment Fee** A *member's* recommended treatment plan may include 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the *member* must pay both: (a) the usual crown or bridge *patient charge* for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Covered Dental Services And Patient Charges section.
- Crown Supporting Existing Partial Denture** A crown may be: (a) placed under an existing partial denture; and (b) be customized to physically support the metal framework of the partial denture. In such case, the *member* must pay the additional *patient charge* for a crown supporting an existing partial denture. This charge is shown in the Covered Dental Services And Patient Charges section. This charge is in addition to the *patient charge* for the crown or bridge unit itself. The *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* must pay the *patient charge* for a multiple crown/bridge unit treatment plan.
- Pediatric Specialty Services** During a *PCD* visit, a *member* under age 6 may be unmanageable. In such case, the *member* may be referred to a *participating pediatric specialist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *PCD* for further services. Subsequent referrals to the *participating pediatric specialist*, if any, must first be authorized by us. Any services performed by a *pediatric specialist* after the *member's* 6th birthday will not be covered. And the *member* must pay the *pediatric specialist's* usual charges.
- Second Opinion Consultation** A *member* may wish to consult another *dentist* for a second opinion regarding services recommended or performed by: (a) his or her *PCD*; or (b) a *participating specialist* through an authorized referral. To have a second opinion consultation covered by us, the *member* must call or write to *Member Services* for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the *plan*.
- A *Member Services Representative* will help the *member* identify a *participating dentist* to perform the second opinion consultation. A *member* may request a second opinion with a *non-participating general dentist* or *specialist dentist*. Also, the *Member Services Representative* will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting *dentist*. The *plan's* benefit for a second opinion consultation is limited to \$50.00. If a *participating dentist* is the consultant, there is no cost to the *member*. If a *non-participating dentist* is the consultant, the *member* must pay any portion of his or her fee over \$50.00.
- Noble And High Noble Metals** The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the *member* must pay: (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.

## Option A

**Orthodontic Services** This *plan* covers orthodontic services as listed under Covered Dental Services And Patient Charges. Coverage is limited to one course of treatment per *member* per lifetime. Treatment must be: (a) preauthorized by *us*; and (b) performed by a participating orthodontist.

The Plan covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, the *member* must pay an added charge for each added month of treatment. Such charge is based on the Participating Orthodontist's contracted fee. If treatment beyond 36 months is required, the contracted fee will no longer apply. The Participating Orthodontist may then charge a prorated charge based on his or her usual fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the plan. If a *member's* coverage terminates after the fixed banding appliances are inserted, the Participating Orthodontist may prorate his or her usual fee over the remaining months of treatment. The *member* is responsible for all payments to the Participating Orthodontist after the termination date.

If a *member* transfers to another participating orthodontist after comprehensive orthodontic treatment has been started, he or she must pay any added costs associated with: (a) the change in orthodontist; and (b) subsequent treatment.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. The *member* must pay for any additional fixed or removable appliances. The benefit for orthodontic retention covers: (a) any and all necessary fixed and removable appliances; and (b) related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances made with: (a) clear; (b) ceramic; (c) white or other optional material; or (d) lingual brackets. The *member* must pay any added costs for the use of optional materials.

If a *member* has orthodontic treatment associated with orthognathic surgery, the *plan* provides its standard orthodontic benefit. Orthognathic surgery is a non-covered procedure which involves the surgical moving of teeth. The *member* must pay any added charges related to: (a) the orthognathic surgery; and (b) the complexity of the orthodontic treatment. The added charges will be based on the participating orthodontist's usual and customary charge.

CGP-3-MDG-ORTH-A-FCW 11/00

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## Option A

### Limitations On Benefits For Specific Covered Services

We don't cover services in excess of any of the following limitations:

- Routine cleaning (prophylaxis) or periodontal maintenance procedure - 2 services in any 12 month period. One periodontal maintenance procedure may be performed by a *participating periodontist* if done within 3 to 6 months following completion of approved, active periodontal therapy by the *participating periodontist*. Such therapy includes periodontal scaling and root planing or periodontal surgery.
- Fluoride treatment - up to the 18th birthday - 2 in any 12 month period.
- Full mouth x-rays - one set in any 3 year period unless diagnostically necessary.
- Bitewing x-rays - 2 sets in any 12 month period unless diagnostically necessary.
- Panoramic x-rays - one in any 3 year period unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one per tooth in any 3 year period.
- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one procedure per quadrant or area in any 3 year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one service per area in any 3 year period.
- Periodontal scaling and root planing - one service per quadrant in any 12 month period.
- *Emergency dental services* when more than 50 miles from the *member's* home - up to \$50.00 per incident, after payment of any *patient charge* which may apply.
- Reline of a complete or partial denture - one per denture in any 12 month period.
- Rebase of a complete or partial denture - one per denture in any 12 month period.
- Second opinion consultation - when approved by *us*, up to \$50.00.

CGP-3-MDG-LMT-FCW

B850.0591

## Option A

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### Exclusions

We won't cover:

- any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease law, or under any other non-dental insurance or benefit plan. This will apply even if the *member* fails to claim his or her rights to such benefit.

## Exclusions (Cont.)

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- dental services performed in a hospital or related hospital fees, or charges for the use of any facility, equipment or supplies provided outside of the *participating dentist's* office.
- any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.
- any treatment of congenital and/or developmental malformations. This will not apply to an otherwise covered service involving congenitally missing teeth or supernumerary teeth.
- any oral surgery requiring the setting of a fracture or dislocation.
- dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- any treatment or appliance: (a) which, in the opinion of the *participating dentist*, Guardian's dental director or his or her authorized agent will not achieve a satisfactory result; or (b) which is solely for cosmetic purposes.
- precision attachments, stress breakers, magnetic retention or overdenture attachments.
- the use of: (a) general anesthesia; (b) intramuscular sedation; (c) intravenous sedation; or (d) inhalation sedation, including but not limited to nitrous oxide.
- any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature, unless coverage is recommended by a utilization review agent.
- replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD*; or (b) treatment by a specialist without referral from the *PCD* and *our* approval.
- treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; (c) splint or stabilize teeth for periodontal reasons; or (d) realign teeth.
- any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- dental services received from any *dentist* other than the selected and assigned *PCD*, unless expressly authorized in writing by the *plan*. This will not apply to *emergency dental services*.

## Exclusions (Cont.)

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- cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- treatment which requires the services of a prosthodontist.
- treatment which requires the services of a *pediatric specialist*, after the *member's* 6th birthday.
- consultations for non-covered services.
- any procedure not listed as a covered service.
- any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- a service started but not completed prior to the *member's* eligibility to receive benefits under the *plan*. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.
- a service started (as defined above) by a *non-participating dentist*. This will not apply to covered *emergency dental services*.
- extractions performed solely to facilitate orthodontic treatment.
- extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- orthognathic surgery and associated incremental charges. Orthognathic surgery is a procedure which involves the surgical moving of teeth.
- procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- replacement or repair of orthodontic appliances damaged due to the neglect of the *member*.

Option A

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**GLOSSARY**

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This Glossary defines the italicized terms appearing in this booklet.

**Alternative Procedure** means a service other than that recommended by the *member's PCD*. But, in the opinion of the *PCD*, such procedure is also an acceptable treatment for the *member's* dental condition.

CGP-3-MDG-DEF1

B850.0595

Option A

**Certificate Of Coverage** means this booklet issued to *you*, which summarizes the essential terms of this *plan*.

CGP-3-MDG-DEF2

B850.0596

Option A

**Dentist** means any dental practitioner 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*.

CGP-3-MDG-DEF3

B850.0597

Option A

**Dependent** means a person listed on the *employee's* enrollment form who is:

- (1) your spouse; or
- (2) your or your spouse's unmarried dependent child who: (a) is less than 20 years of age, or less than 26 if a full-time student, and (b) depends primarily on *you* or your spouse for support and maintenance.

The term "dependent child" as used in this *plan* will include any (a) stepchild; (b) newborn child; (c) legally adopted child; (d) child for whom *you* are a court-appointed legal guardian; or (e) proposed adoptive child during any waiting period prior to the formal adoption if the child is a part of your household and is primarily dependent on *you* for support and maintenance. The term also includes any child for whom a court-ordered decree requires *you* to provide dependent coverage.

- (3) A mentally retarded or physically handicapped *dependent child* who:
  - (1) has reached the upper age limit of a *dependent child*; (2) is not capable of self-sustaining work; and (3) depends primarily on *you* for support and maintenance. *You* must furnish proof of such lack of capacity and dependence to us within 31 days after the child reaches the limiting age, and each year after that, on *our* request.

The term "dependent" does not include a person who is also covered as an *employee* for benefits under any dental plan which your *employer* offers, including this one.

CGP-3-MDG-DEF-4C

B850.0600

**Option A**

**Emergency Dental Services** mean only covered, bona fide emergency services which are reasonably necessary to: (a) relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort; or (b) prevent the imminent loss of teeth. Services related to the initial emergency condition that are not bona fide emergency services, as described above, are not considered *emergency dental services*. This includes: (a) services performed at the emergency visit; and (b) services performed at later visits.

CGP-3-MDG-DEF5

B850.0604

**Option A**

**Employee or You** means the person to whom this booklet is issued: (a) who meets your *employer's* eligibility requirements; and (b) for whom monthly payments are made by your *employer*.

CGP-3-MDG-DEF6

B850.0605

**Option A**

**Employer Or Planholder** means the *employer* or other entity: (a) with whom or to whom this *plan* is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its *members*.

CGP-3-MDG-DEF7

B850.0606

**Option A**

**Member** means *you* and any of your eligible *dependents*: (a) as defined under the eligibility requirements of this *plan*; and (b) as determined by your *employer*, who are actually enrolled in and eligible to receive benefits under this *plan*.

CGP-3-MDG-DEF8

B850.0607

**Option A**

**Non-Participating Dentist** means any *dentist* that does not have an MDG participation agreement in force with *us* to provide dental services to *members*.

CGP-3-MDG-DEF9

B850.0608

**Option A**

**Participating Dentist** means a *dentist* who has an MDG participation agreement in force with *us*. This term includes any hygienist and technician recognized by the dental profession who assists and acts under the supervision of a *participating dentist*.

CGP-3-MDG-DEF10

B850.0609

**Option A**

**Participating General Dentist** means a *dentist* who has an MDG participation agreement in force with *us*: (a) who is listed in MDG's directory of *participating dentists* as a general practice *dentist*; and (b) who may be selected as a *PCD* by a *member* and assigned by MDG to provide or arrange for a *member's* dental services.

CGP-3-MDG-DEF11

B850.0610

**Option A**

**Participating Specialist** means a *dentist* who has an MDG participation agreement in force with *us* as an: (a) *Endodontist*; (b) *Pediatric Specialist*; (c) *Periodontist*; (d) *Oral Surgeon*; or (e) *Orthodontist*.

CGP-3-MDG-DEF12B

B850.0612

**Option A**

**Patient Charge** means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this *plan*. Such amount is the patient's portion of the cost of covered dental services.

CGP-3-MDG-DEF13

B850.0613

**Option A**

**Plan** means the Guardian *plan* of group dental benefits described in this booklet.

CGP-3-MDG-DEF14

B850.0614

**Option A**

**Primary Care Dentist (PCD)** means a dental office location: (a) at which one or more *participating general dentists* provide *covered services* to *members*; and (b) which has been selected by a *member* and assigned by MDG to provide and arrange for his or her dental services.

CGP-3-MDG-DEF15

B850.0615

**Option A**

**Service Area** means the geographic area in which we are licensed to provide dental services for *members*.

CGP-3-MDG-DEF16

B850.0616

**Option A**

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

CGP-3-MDG-DEF17

B850.0617

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## COORDINATION OF BENEFITS

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### Applicability

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This Coordination of Benefits provision applies when a *member* has dental coverage under more than one plan.

When a *member* has dental coverage from more than one plan, this *plan* coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated.

As used here:

"Plan" means any of the following that provides dental expense benefits or services:

- (1) group or blanket insurance plans;
- (2) group coverage under prepayment, group practice and individual practice plans;
- (3) union welfare plans, employer plans, employee benefits plans, trustee labor and management plans, or other plans for members of a group; and
- (4) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other government program or coverage which *we* are not allowed to coordinate with by law. Plan also does not include blanket school accident-type coverage.

"This *plan*" means the part of this *plan* subject to this provision.

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### How This Provision Works: The Order of Benefits

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*We* apply this provision when a *member* is covered by more than one plan. When this happens *we* consider each plan separately when coordinating payments.

In applying this provision, one of the plans is called the primary plan. A secondary plan is one which is not a primary plan. The primary plan pays first, ignoring all other plans. If a *member* is covered by more than one secondary plan, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that secondary plan.

If a plan has no coordination provision, it is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

- (1) A plan that covers a *member* as an *employee* pays first, the plan that covers a *member* as a *dependent* pays second;

## How This Provision Works: The Order of Benefits (Cont.)

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- (2) Except for *dependent* children of separated or divorced parents, the following governs which plan pays first when this *plan* and another plan cover the same child as a *dependent*:
- (a) The benefits of the plan of the parent whose birthday falls earlier in the calendar year pays first. The plan that covers a *dependent* child of the parent whose birthday falls later in the calendar year pays second; but
  - (b) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the other plan.
  - (c) If the benefits of the plan with which we're coordinating does not have a similar provision, then (b) will not apply and the other plan's coordination provision will determine the order of benefits.

"Birthday" refers only to month and day in a calendar year, not the year in which the parent was born.

- (3) For a *dependent* child of separated or divorced parents, benefits for that child are determined in this order:
- (a) first, the plan of the parent with custody of the child;
  - (b) then, the plan of the spouse of the parent with custody of the child;
  - (c) finally, the plan of the parent not having custody of the child; and
  - (d) if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (4) A plan that covers a *member* as an active *employee* or as a *dependent* of such *employee* pays first. A plan that covers a person as a laid-off or retired *employee* or as a *dependent* of such *employee* pays second.

If the plan with which we're coordinating does not have a similar provision for such persons, then (4) will not apply.

If rules (1), (2), (3) and (4) don't determine which plan pays first, the plan that has covered the person for the longer time pays first.

To determine the length of time a *member* has been insured under a plan, two plans will be treated as one if the *member* was eligible under the second within 24 hours after the first plan ended.

The *member's* length of time covered under one plan is measured from his or her first date of coverage under the plan. If that date is not readily available, the date the *member* first became a *member* of the group will be used.



## Option A

### How This Provision Works: Coordination of Benefits

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**Coordination With A Pre-Paid Dental Plan** A *member* may also be covered under a pre-paid dental plan where *members* pay only a fixed payment amount for each covered service.

For *PCDs'* services, when the *PCD* participates under both plans, the *member* will never have to pay more than this *plan's patient charge*.

For *PCDs'* services when the *PCD* participates under this *plan* only:

- when this *plan* is primary, the *PCD* submits a claim to the secondary plan for the *patient charge* amount. Any payment made by the secondary carrier must be deducted from the *member's* payment.
- when this *plan* is secondary, the *PCD* submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the *patient charge*, reducing the *member's* out-of-pocket expense.

For *participating specialists'* services and *emergency dental services* within the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, any payment made by the primary carrier is credited against the *patient charge*. In many cases, the *member* will have no out-of-pocket expenses.

For *emergency dental services* outside the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this plan is secondary, *we* pay for covered services not paid by the primary plan, up to \$50.00, after payment of any *patient charge* which may apply.

**Coordination With An Indemnity Or PPO Dental Plan** When a *member* is covered by this plan and a fee-for-service plan, the rules which follow will apply:

For *PCDs'* services:

- when this *plan* is primary, the *PCD* submits a claim to the secondary plan for the *patient charge* amount. Any payment made by the secondary carrier must be deducted from the *member's* payment.
- when this *plan* is secondary, the *PCD* submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the *patient charge*, reducing the *member's* out-of-pocket expense.

For *participating specialists'* services and *emergency dental services* within the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.

## **How This Provision Works: Coordination of Benefits (Cont.)**

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- when this *plan* is secondary, any payment made by the primary carrier is credited against the *patient charge*, reducing the *member's* out-of-pocket expense.

For *emergency dental services* outside the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, *we* pay for covered services not paid by the primary plan, up to \$50.00, after payment of any *patient charge* which may apply.

## **Our Right To Certain Information**

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In order to coordinate benefits, *we* need certain information. A *member* must supply *us* with as much of that information as he or she can. If he or she can't give *us* all the information *we* need, *we* have the right to get this information from any source. If another insurer needs information to apply its coordination provision, *we* have the right to give that insurer such information. If *we* give or get information under this section, *we* can't be held liable for such action except as required by law.

When payments that should have been made by this *plan* have been made by another plan, *we* have the right to repay that plan. If *we* do so, *we're* no longer liable for that amount. If *we* pay out more than *we* should have, *we* have the right to recover the excess payment.

CGP-3-MDG-COB2-NY

B850.0619

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## STATEMENT OF ERISA RIGHTS

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As a participant, *you* are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all *plan* participants shall be entitled to:

- (a) Examine, without charge, all *plan* documents, including contracts, collective bargaining agreements and copies of all documents filed by the *plan* with the U.S. Department of Labor, such as detailed annual reports and *plan* descriptions. The documents may be examined at the *plan* Administrator's office and at other specified locations such as worksites and union halls.
- (b) Obtain copies of all *plan* documents and other *plan* information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
- (c) Receive a summary of the *plan's* annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people, called "fiduciaries," who are responsible for the operation of your benefit *plan*. They have a duty to operate the *plan* prudently and in the interest of *plan* participants and beneficiaries. Your *employer* may not fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must send him or her a written explanation of the reason for the denial. *You* have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, *you* may file suit in a federal court if *you* request materials from the *plan* and do not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay *you* up to \$110.00 a day until *you* receive them (unless the materials were not sent because of reasons beyond the Administrator's control.) If your claim for benefits is denied in whole or in part, or ignored, *you* may file suit in a state or federal court. If *plan* fiduciaries misuse the *plan's* money, or discriminate against *you* for asserting your rights, *you* may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If *you* lose, the court may order *you* to pay: for example, if it finds your claim is frivolous. If *you* have any questions about your *plan*, *you* should contact the Plan Administrator. If *you* have any questions about this statement or about your rights under ERISA, *you* should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

*We* agree to duly investigate and endeavor to resolve any and all complaints received from *members* with regard to the nature of professional services rendered. Any inquiries or complaints may be made to Guardian by writing or calling *us* at the address and telephone indicated in this booklet.

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## CERTIFICATE AMENDMENT

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(To be attached to *your* Certificate)

Amendment Effective: The later of (i) the effective date of *your* certificate; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by Guardian.

This rider amends *your* Certificate as follows:

The section of *your* Certificate entitled "When Coverage Ends" is replaced by the following:

**When Coverage Ends** Subject to any continuation of coverage privilege which may be available to *you* or *your dependents*, coverage under this *plan* ends when *your employer's* coverage terminates. *Your* and *your dependents* coverage also ends on the first to occur of:

1. Upon *your* failure to pay the required premium in accordance with the provisions of this *plan*, if *you* are required to pay any part of this *plan*.
2. For *you*, the end of the month in which *you* cease to be eligible for coverage under this *plan*.
3. For *your dependents*:
  - For *your dependent* spouse, the end of the month in which *your* spouse is no longer a *dependent* as defined in this *plan*;
  - For *your dependent* child, the end of the month in which *your* child is no longer a *dependent* as defined in this *plan*;
4. If *you* or *your dependent* has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing:
  - on his/her enrollment application, or
  - in order to obtain coverage for a service,

coverage will terminate immediately upon written notice of termination delivered by *us* to *you* or *your dependent*.

But, if *you* or *your dependent* makes an intentional misrepresentation of material fact in writing on his/her enrollment application *we* will rescind coverage if the facts misrepresented would have led *us* to refuse to issue the coverage. Rescission means that the termination of *your* coverage will have a retroactive effect of up to *your* enrollment under the certificate.

If termination is a result of *your* action, coverage will terminate for *you* and any *dependents*. If termination is a result of *your dependent's* action, coverage will terminate for the *dependent*.

Member termination under item (4) above is subject to the rights of appeal described in the Grievance Process section of the plan.

What we cover is based on all the terms of this plan.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

**The Guardian** Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Raymond J. Marra". The signature is written in a cursive style with a large initial 'R'.

Raymond Marra, Senior Vice President, Group and Worksite Markets

CGP-3-MDG-DENDEP-17-NY

B850.1597

## All Options

### NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

#### **What is Protected Health Information (PHI):**

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

#### **In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):**

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment.Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment.Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders.Guardian may use and disclose your PHI to contact you and remind you of appointments.

## **The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

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### **All Options**

Guardian is required to use or disclose your PHI :

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.
  
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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**All Options**

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

**Your Rights with Regard to Your Protected Health Information (PHI):**

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.



**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at [www.guardianlife.com/privacy-policy](http://www.guardianlife.com/privacy-policy).

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

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**All Options**

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

Your Right to Amend Your PHI. If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

**How to Contact Us:**

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

**Attention:**

Guardian Corporate Privacy Officer  
National Operations

**Address:**

The Guardian Life Insurance Company of America  
Group Quality Assurance - Northeast  
P.O. Box 981573  
El Paso, TX 79998-1573

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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)



**The Guardian Life Insurance  
Company of America**  
7 Hanover Square  
New York, New York 10004-2616

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