

The GUARDIAN Life Insurance Company of America
A Mutual Life Insurance Company
7 Hanover Square, New York, New York 10004

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Policy No. G- 00433322-

(To be attached to and made a part of the Policy)

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00433322- is hereby amended effective June 28, 2019 as follows:

Your Employer Rider is hereby declared null and void and replaced with the revised corresponding Employer Rider attached hereto.

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
7 Hanover Square, New York, New York 10004

POLICYHOLDER: WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY

GROUP POLICY NUMBER

G-00433322

DELIVERED IN

New York

POLICY DATE

January 1, 2008

POLICY ANNIVERSARIES: January 1st of each year, beginning in 2009

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (herein called the Insurance Company) in consideration of the Application for this Policy and of the payment of premiums as stated herein, **AGREES** to pay benefits in accordance with and subject to the terms of this Policy.

Premiums are payable by the Policyholder as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are, during the continuance of this Policy, due on the 1st of each month

This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Policy.

This Policy takes effect on the Policy Date specified above.

IN WITNESS WHEREOF, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of July 1, 2019 which is its date of issue.

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

**GROUP INSURANCE POLICY
PROVIDING
BENEFITS AS DESCRIBED HEREIN**

Dividends Apportioned Annually

SCHEDULE OF INSURANCE AND PREMIUM RATES

This plan's classifications, and the option packages of benefits which are available to covered persons who are members of each classification, are shown below.

Class Description

Class 0001 ALL ELIGIBLE EMPLOYEES

GP-1-SI

P130.1566

Option Packages Available

Employees may choose from the benefit packages available to members of their class. The option packages are summarized in "Summary of Option Packages" below.

GP-1-SI

P130.1710

Members of Class 0001 may choose from benefit option packages A and B.

GP-1-SI

P130.1568

Summary of Option Packages

The following are summaries of the benefit option packages available. For a complete explanation of the benefits provided by this plan, including all limitations and exclusions, please read the entire plan.

GP-1-SI

P130.1585

Option B Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 80% and major services paid at a rate of 50%. A benefit year deductible of \$50.00 applies to the services. A lower level of benefits is paid if the covered person does not use the services of a preferred provider.

GP-1-SI

P130.1835

Option B**Schedule of Benefits**
Employee and Dependent Dental Expense

GP-1-SI

P130.9303

Option B

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

Group 1 Services	None
Group 2 and 3 Services	\$50.00

for each covered person

Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services:

Group 1 Services	None
Group 2 and 3 Services	\$100.00

for each covered person

GP-1-SI

P130.1446

Option B

Payment Rates Payment Rate for Services Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	80%
Group 3 Services	50%

Payment Rate for Services **Not** Furnished By A Preferred Provider:

Group 1 Services	100%
Group 2 Services	80%
Group 3 Services	50%

GP-1-SI

P130.1381

Option B

Payment Limits Benefit Year Payment Limit
for Non-Orthodontic 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.

A "benefit year" is a 12 month period which starts on January 1st and ends on December 31st of each year.

GP-1-SI

P130.4987

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.

GP-1-SI

P130.9093

Option B

Group Enrollment Period A group enrollment period is held each year. The group enrollment period is a time period agreed to by the employer and us. During this period, eligible employees may elect to enroll in dental insurance under this plan. Coverage starts on the first day of the month that next follow the date of enrollment. The employee and his or her

Schedule of Benefits

Employee and Dependent Dental Expense (Cont.)

eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.

GP-1-SI

P130.8677

Option B

Schedule of Benefits

Effective Dates for Changes to Insurance

GP-1-SI

P130.3343

Option B

Changes in Insurance Amounts

Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the Employee's classification, except that any increase in the amount of insurance on an Employee or a Qualified Dependent eligible for benefits under an established benefit period shall become effective:

- in the case of an Employee not actively at work, on the day on which he returns to active work on a full-time basis (or the day on which his benefit period terminates, whichever is later) or
- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

In no event shall the insurance of an Eligible Dependent of an Employee who is not actively at work on a full-time basis be increased or decreased prior to the date such Employee returns to active work on a full-time basis.

GP-1-SI

P130.9324

Schedule of Premium Rates

The monthly premium rates, in U.S. dollars, for the insurance provided under this plan are listed below.

GP-1-SI

P130.9260

Option B

Premium Rates

Dental Expense Insurance

GP-1-SI

P130.2834

Option B Class 0001

**Rate per
Employee**

**per Employee
and Insured
Spouse with no
Insured Child**

**per Employee
and Insured
Child(ren) with
no Insured
Spouse**

**per Employee
and Insured
Family**

\$ 67.55

\$ 131.30

\$ 155.46

\$ 219.20

GP-1-SI

P130.1539

We have the right to change any premium rate(s) set forth above at the times and in the manner established by the provision of the group plan entitled "Premiums".

GP-1-SI

P130.9298

Option B

GENERAL PROVISIONS

Definitions

As used in this policy:

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

"Plan" means this group insurance policy.

"Covered person" means an employee or dependent insured by this policy.

GP-1-R-GENPRO-90

P140.0136

Option B

Incontestability

This policy shall be incontestable after two years from its policy date, except for non-payment of premiums.

No statement in any application made by a person insured under this policy 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 policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or a covered person's signed application for up to two years from this policy's policy date.

GP-1-R-INCY-NY-01

P140.0314

Option B

Associated Companies

An associated company is a corporation or other business entity affiliated with the policyholder through common ownership of stock or assets.

If the policyholder asks us in writing to include an associated company under this policy, and we give our written approval, we'll treat employees of that company like the policyholder's employees. Our written approval will include the starting date of the company's coverage under this policy. But each eligible employee of that company must still meet all of the terms and conditions of this policy before he'll be insured.

The policyholder must notify us in writing when a company stops being associated with him. On the date a company stops being an associated company, this policy will end for all of that company's employees, except those employed by the policyholder or another covered associated company as eligible employees, on such date.

GP-1-R-AC-90

P140.0151

Option B

Premiums

Premiums due under this policy must be paid by the policyholder at an office of the Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of this policy, unless by agreement between the policyholder and the Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi- annually, quarterly or monthly.

The premium due under this policy on each policy due date will be the sum of the premium charges for the insurance coverages provided under this policy. The premium charges are based upon the rates set forth in this policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates: (a) on the first day of any policy month; (b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy; (c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (d) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

We must give the policyholder 31 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustment of Premiums Payable Other Than Monthly or Quarterly

Under the above provision, if a premium rate is changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change, the premium will be adjusted by a proportionate increase or decrease for the unexpired period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to the policyholder by us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This policy's grace period provisions will apply to any such premium due.

Grace in Payment of Premiums - Termination of Policy

A grace period of 31 days, without interest charge, will be allowed the policyholder for each premium payment except the first. If any premium is not paid before the end of the grace period, this policy automatically ends at the end of the grace period. However, if the policyholder gives us advance written notice of an earlier termination date during the grace period, this policy will end as of such earlier date.

If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

This policy ends immediately on any date when an insurance coverage under this policy ends and, as a result, no benefits remain in effect under this policy.

GP-1-R-PREM-90

P140.0529

Option B

Term of Policy - Renewal Privilege

This policy is issued for a term of one (1) year from the policy date shown on the first page of this policy. All policy years and policy months will be calculated from the policy date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the policyholder's place of business.

If this policy provides coverage on a non-contributory basis, 100% of the employees eligible for insurance must be enrolled for coverage. If dependent coverage is provided on a non-contributory basis, all eligible dependents must be enrolled.

The policyholder may renew this policy for a further term of one (1) year, on the first and each subsequent policy anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this policy's "Premiums" section.

However, we have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date: (a) less than 10 employees are insured under this policy; or (b) with respect to a non-contributory policy, less than 100% of those employees eligible are insured under this policy; or (c) with respect to a contributory policy, less than 75% of those employees eligible are insured under this policy.

If this policy provides dependents coverage, we may decline to renew such coverage on any policy anniversary or premium due date, if: (a) with respect to a non-contributory policy, less than 100% of all eligible dependents are enrolled for coverage under this policy; or (b) with respect to a contributory policy, less than 75% of those employees eligible for dependents coverage are insured as such.

The policyholder may cancel this policy at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. And the employer will owe us all unpaid premiums for the period this plan is in force.

The Contract

The entire contract between the Guardian and the policyholder consists of this policy, and the policyholder's application, a copy of which is attached hereto or endorsed hereon.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

Any amendments to this policy will be without prejudice to any claim arising prior to the date of the change.

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, policy or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or policy, or any requirements of The Guardian; or (c) bind us by any statement or promise relating to the insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

GP-1-R-TERM-90

P140.0161

Option B

Clerical Error - Misstatements

Neither clerical error by the policyholder, a participating employer or the Guardian in keeping any records pertaining to insurance under this policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the policyholder will be limited to the period of 90 days preceding the date of our receipt of satisfactory evidence that such adjustments should be made.

If the age of an employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of insurance, the true facts will be used in determining whether insurance is in force under the terms of this policy, and in what amount.

Statements

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90

P140.0309

Option B

Assignment

An employee's right to assign any interest under this policy is governed as follows:

- Any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

Assignment By Policyholder

Assignment or transfer of the interest of the policyholder will not bind us without our written consent thereto.

GP-1-R-ASSIGN-90

P140.0165

Option B

Dividends

The portion, if any, of the divisible surplus of the Guardian allocable to this policy at each policy anniversary will be determined annually by the Board of Directors of the Guardian and will be credited to this policy as a dividend on such anniversary, provided this policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this policy will be paid to the policyholder in cash, or at the option of the policyholder it may be applied to the reduction of the premiums then due.

In the event that the employees are contributing toward the cost of the coverage under any group policy issued to the policyholder and the aggregate dividends under this policy and any other group policy or policies issued to the policyholder are in excess of the policyholder's share of the aggregate cost, such excess will be applied by the policyholder for the sole benefit of the employees.

Payment of any dividend to the policyholder will completely discharge our liability with respect to the dividend so paid.

GP-1-R-DIV-90

P140.0168

Option B

Employee's Certificate

We will issue to the policyholder, for delivery to each employee insured under this policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. But the certificate does not constitute a part of this policy and will in no way modify any of the terms and conditions set forth in this policy.

In the event this policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the policyholder for delivery to affected employees.

Claims of Creditors

Except when prohibited by the laws of the jurisdiction in which this policy was issued, the insurance and other benefits under this policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Records - Information To Be Furnished.

The policyholder must keep a record of the insured employees containing, for each employee, the essential particulars of the insurance which apply to the employee. The policyholder must periodically forward to us, on our forms, such information concerning the employees in the classes eligible for insurance under this policy as may reasonably be considered to have a bearing on the administration of the insurance under this policy and on the determination of the premium rates. For benefits which are based on an employee's salary, changes in an employee's salary must promptly be reported to us. The policyholder's payroll and other such records which have a bearing on the insurance must be furnished to us at our request at any reasonable time.

GP-1-R-CERT-90

P140.0167

Option B

Accident And Health Claims Provisions

An employee's right to make a claim for any accident and health benefits provided by this plan is governed as follows:

Notice: The employee 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 his name and plan number. If the claim is being made for one of the employee's covered dependents, the dependent's name should also be noted.

Proof of Loss: We'll furnish the employee 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. The employee must detail the nature and extent of the loss for which the claim is being made.

If this plan provides weekly loss-of-time insurance, the employee must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, he must send us written proof of loss within 90 days of the date we request. For any other loss, he must send us written proof within 120 days of the loss.

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

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

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

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

Limitation of Actions: The employee can't bring a legal action against this plan until 60 days from the date he files proof of loss. And he can't bring legal action against this plan after three years from the date he files proof of loss.

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

GP-1-R-AH-90

P140.0668

Option B

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.

GP-1-R-NCC-87

P240.0058

Option B

Federal Continuation Rights

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 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 an Employee's Group Health Benefits End: If an employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if he or she was not terminated due to gross misconduct.

The continuation: (a) may cover the employee 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 the employee's 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.

To elect the extra 11 months of continuation, a qualified continuee must give you 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 you 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 you during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

GP-1-R-COBRA-96-1

P235.0395

Option B

If an Employee Dies While Insured: If an employee dies 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".

GP-1-R-COBRA-96-2

P235.0096

Option B

If an Employee's Marriage Ends: If an employee's 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 the employee's 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 the employee's 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.

Special Medicare Rule: If the employee becomes 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 the employee's 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 the employee's termination of employment or reduction of work hours; or (b) 36 months from the date of the employee's 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 you, in writing, of: (a) the legal divorce or legal separation of the employee from his or her 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 you by a qualified continuee within 60 days of the latest of: (a) the date on which the event 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 you and this plan's procedures for providing such notice.

Notice of a disability determination must be given to you 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 you 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.

Such notice must be given to you within 60 days of either of these events.

GP-1-R-COBRA-96-3

P235.0126

Option B

Your 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.

You must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) the employee's death; (b) the employee's termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) the employee's Medicare entitlement; or (d) in the case of a retired employee, your bankruptcy proceeding under Title 11 of the United States Code.

Upon receipt of notice of a qualifying event from an 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 you are also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, you 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 you determine that an individual is not eligible for continued group health benefits under this plan, you 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, you must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Your Liability: You will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) you fail 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) you fail 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 you 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 you 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 you, by the qualified continuee, in advance, at the times and in the manner specified by you. 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 you. 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 you.

If the qualified continuee fails to give you 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 you notify the qualified continuee of the amount of the deficiency and grant 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 you.

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

- (1) with respect to continuation upon the employee's 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 the employee's death, the employee's 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 you cease 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.

GP-1-R-COBRA-96-4

P235.0142

Option B

Uniformed Services Continuation Rights

An employee who enters or returns from military service, may have special rights under this plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If an employee's group health benefits under this plan would otherwise end because he or she enters into active military service, this plan will allow the employee, or his or her 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 the employee is 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 the employee fails to return to work in a timely manner after military service ends as provided under USERRA. You must provide the employee with details about this continuation provision including required premium payments.

GP-1-R-COBRA-96-4

P235.0139

Option B

ELIGIBILITY FOR DENTAL COVERAGE

P489.0005

Option B

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0

P180.0168

Option B

Enrollment Requirement: If an employee must pay part of the cost of employee coverage, we won't insure him until he enrolls in the plan and agrees to make the required payments. If he does this: (a) more than 31 days after he first becomes eligible; or (b) after he previously had coverage which ended because he failed to make a required payment, we will consider the employee to be a late entrant.

If an employee initially waived dental coverage under this plan because he or she was covered under another group plan, and he or she now elects to enroll in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to him or her with regard to dental coverage provided his or her coverage under the other plan ends due to one of the following events:

- (a) termination of his or her spouse's employment;
- (b) loss of eligibility under his or her spouse's plan;
- (c) divorce;
- (d) death of his or her spouse; or
- (e) termination of the other plan.

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

GP-1-EC-90-2.0

P180.0963

Option B for Class 0001

Dental Plan Election Procedures: Since you offer your employees Managed DentalGuard as an alternative to this dental coverage, each employee who is enrolled in this coverage may change his or her election, and enroll in Managed DentalGuard as follows.

If the employee drops his or her coverage under this plan, at any time other than during an open enrollment period, he or she may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If the employee remains covered under this plan, he or she may change his or her election, and enroll in Managed DentalGuard during an open enrollment period. The employee's 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 an employee changes his or her election, the employee's covered dependents will automatically be switched to Managed DentalGuard at the same time as the employee.

GP-1-EC-90-2.0

P489.0108

Option B

The Waiting Period: Employees in an eligible class are eligible for dental insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0

P489.0004

Option B

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0

P180.0328

Option B for Class 0001

When Employee Coverage Starts

An employee must be actively at work, and working his regular number of hours, on the date his coverage is scheduled to start. And he must have met all of the conditions of eligibility which apply to him. If an employee is not actively at work on his scheduled effective date, we will postpone the start of his coverage until he returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he was actively at work, and working his regular number of hours, on his last regularly scheduled work day.

The scheduled effective date of an employee's coverage is as follows:

- If an employee must pay part of the cost of employee coverage, then he must elect to enroll and agree to make the required payments. If he does this on or before the eligibility date, his coverage is scheduled to start on his eligibility date. If he does this after his eligibility date, his coverage is scheduled to start on the date he signs his enrollment form.

- On non-contributory plans, subject to all the terms of this plan, an employee's coverage is scheduled to start on his eligibility date.

GP-1-EC-90-6.0

P180.0969

Option B for Class 0001

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0

P489.0006

Option B for Class 0001

When Active Service Ends: You may continue an employee's dental expense insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.
- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0

P489.0002

Option B

An Employee's Right To Continue Group Insurance During A Family Leave Of Absence

Important Notice: This section may not apply to your plan. The employee must contact you to find out if you must allow for a leave of absence under federal law. In that case the section applies.

If An Employee's 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: Insurance may continue until the earliest of the following:

- The date the employee returns 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 the employee's coverage would have ended had the employee 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.
- **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,

GP-1-EC-90-7.0

P449.0523

Option B

Definitions

GP-1-EC-90-DEF-1

P180.0155

Option B

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

GP-1-EC-90-DEF-2

P180.0156

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.

GP-1-EC-90-DEF-3

P180.0311

Class 0001

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.

GP-1-EC-90-DEF-4

P180.0158

Option B

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-EC-90-DEF-6

P180.0160

Option B

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

GP-1-EC-90-DEF-9

P180.0163

Option B

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10

P180.0164

Option B

Dependent Coverage

GP-1-DEP-90-1.0

P200.0305

Option B

Eligible Dependents For Dependent Dental Benefits: An employee's eligible dependents are: (a) his or her legal spouse; (b) his or her unmarried dependent children who are under age 20; and (c) his or her 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. The employee 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.

GP-1-DEP-90-2.0

P489.0300

Option B

Adopted and Step-Children: An employee's "unmarried dependent children" include his or her dependent legally adopted children and, if they depend on him or her for most of their support and maintenance, his or her 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.

GP-1-DEP-91-3.1-NY

P489.0061

Option B

Handicapped Children: An employee 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 the age limit; (b) he or she became insured 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 the employee for most of his or her support and maintenance.

But, for the child to stay eligible, the employee must send us written proof that the child is handicapped and depends on the employee for most of his or her support and maintenance. The employee has 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 the employee's does.

GP-1-DEP-90-4.0

P489.0030

Option B

Waiver of Dental Late Entrants Penalty: If an employee initially waived dental coverage for his or her spouse or eligible dependent children because they were covered under another group plan, and he or she now elects 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 his or her spouse's employment;
- (b) loss of eligibility under his or her spouse's plan;
- (c) divorce;
- (d) death of his or her spouse; or
- (e) termination of the other plan.

But the employee must enroll his or her 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.

And, the Penalty for Late Entrants provisions for dental coverage will not apply to the employee's spouse or eligible dependent children if: (a) he or she is under legal obligation to provide dental coverage due to a court-order; and (b) he or she enrolls them in the dental coverage under this plan within 30 days of the issuance of the court-order.

GP-1-DEP-90-5.0

P200.0771

Option B for Class 0001

When Dependent Coverage Starts: In order for an employee's dependent coverage to begin he or she 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 an employee's dependent coverage starts depends on when he or she elects to enroll his or her initial dependents and agrees to make any required payments.

If the employee does this on or before his or her 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 the employee's eligibility date and the date the employee becomes insured for employee coverage.

If the employee does 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 the employee signs the enrollment form; and the date the employee becomes insured for employee coverage.

If the employee does this after the enrollment period ends, each of an employee's 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 the employee signs the enrollment form.

Once an employee has dependent coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents and agree to make any additional payments required for their coverage.

If an employee does 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 an employee fails 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 the employee signs the enrollment form.

GP-1-DEP-90-6.0

P489.0063

Option B

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

GP-1-DEP-90-7.0

P200.0708

Option B

Newborn and Adopted children: We cover an employee's newborn child for dependent benefits, from the moment of birth. We also cover an employee's adopted child for dependent benefits from the moment of birth if the employee takes physical custody of the child upon such child's release from the hospital and the employee files a petition for adoption within 30 days of the child's birth.

We do this only if: (a) the employee is already covered for dependent child coverage when the child is born, adopted or placed for adoption; or (b) the employee enrolls the child and agrees to make any required premium payments within 31 days of the date the child is born, adopted or placed for adoption. If the employee fails 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 the employee signs the enrollment form.

GP-1-DEP-90-8.0

P489.0097

Option B

When Dependent Coverage Ends: Dependent coverage ends for all of an employee's dependents when his or her employee coverage ends. But if an employee dies while insured, we'll automatically continue dependent benefits for those of his or her dependents who were insured when he or she 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 an employee's dependents when the employee stops 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.

If an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she 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 coverage'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 the employee 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.

GP-1-DEP-90-9.0

P449.0551

Option B

Definitions

GP-1-DEP-90-DEF-1

P200.0210

Option B

Eligibility Date for dependent coverage is the earliest date on which: (a) the employee has dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2

P200.0211

Option B

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

GP-1-DEP-90-DEF-3

P200.0212

Option B

Enrollment Period means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4

P200.0213

Option B

Initial Dependents means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. If at this time he or she does not have any eligible dependents, but later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8

P200.0217

Option B

Newly Acquired Dependent means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9

P200.0218

Option B

Plan means the Guardian group plan purchased by the employer, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

GP-1-DEP-90-DEF-11

P200.0220

Option B

We, Us, Our and Guardian means The Guardian Life Insurance Company of America.

GP-1-DEP-90-DEF-14

P200.0223

Option B

You and **Your** means the employer who purchased this plan.

GP-1-DEP-90-DEF-15

P200.0224

Option B

DENTAL EXPENSE INSURANCE

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.

GP-1-DG2000

P498.0007

Option B

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

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*.

GP-1-DGY2K-PPO

P498.0165

Option B

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.

GP-1-DGY2K-CC

P498.0079

Option B

Appeals Process

External Appeal

Right To An External Appeal: 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.

Right To Appeal A Determination That A Service Is Not Medically Necessary: 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:

- The service, procedure or treatment must be covered by this plan; and
- 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.

Right To Appeal A Determination That A Service Is Experimental Or Investigational: If coverage has been denied on the basis that the service is experimental or investigational, he or she must satisfy both of the following:

- The service must be covered by this plan; and
- 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.

The External Appeal Process: 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.

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.

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.

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.

GP-1-DGY2K-APPL

P498.0391

Option B

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.

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.

GP-1-DGY2K-AT-NJ

P498.0323

Option B

Pre-Treatment Review

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

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*.

GP-1-DGY2K-PTR

P498.0004

Option B

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this *plan*. For instance, an employee may be covered by this *plan* and a similar plan through his or her spouse's employer. He or she 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.

GP-1-DGY2K-OS

P498.0005

Option B

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.

GP-1-DGY2K-LE

P498.2094

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*.

The *benefit year* deductibles, shown in the schedule, apply to Group II and III services. There are different *benefit year* deductible amounts for services provided by a *preferred provider* and 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*.

GP-1-DGY2K-BP

P498.0195

Option B

All covered charges must be incurred while insured. And what *we* pay is subject to the *benefit year payment limit* shown in the schedule and to all of the terms of this *plan*.

GP-1-DGY2K-BP

P498.0210

Option B

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 Non-Orthodontic Services" for details.

GP-1-DG-ROLL-04-2.1

P498.2168

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:

- 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 provisions 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*.

GP-1-DG-ROLL-04-2

P498.9356

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*.

GP-1-DGY2K-FL

P498.0085

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%

GP-1-DGY2K-PR

P498.0090

Option B

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.

GP-1-DGY2K-END

P498.0138

Option B

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.

GP-1-DGY2K-TL-NY

P498.0390

Option B

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.

GP-1-DGY2K-PP

P498.1784

Option B

Exclusions

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

GP-1-DGY2K-EXCH-01-NY

P498.2939

Option B

List Of Covered Dental Services

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.

GP-1-DNTL-90-13

P490.0147

Option B

Group I - Preventive Dental Services (Non-Orthodontic)

GP-1-DNTL-90-14

P498.8633

Option B

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.

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.

GP-1-DNTL-90-14

P498.5009

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.

GP-1-DNTL-90-15

P498.0182

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

GP-1-DNTL-90-15

P498.0183

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.

GP-1-DNTL-90-14

P498.0184

Option B

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.

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.

GP-1-DNTL-90-15

P498.2884

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

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 reline, 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 reline is done by the *dentist* who furnished the denture. Limited to reline 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 reline 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.

GP-1-DNTL-90-15

P498.1076

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

GP-1-DNTL-90-15

P498.0219

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.

GP-1-DNTL-90-15

P498.0220

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.

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

GP-1-DNTL-90-15

P498.0221

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

GP-1-DNTL-90-15

P498.1078

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.

GP-1-DNTL-90-15

P498.0224

Option B

Group III - Major Dental Services
(Non-Orthodontic)

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

Single Crowns

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

Inlays

Onlays, including inlay

Labial veneers

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

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

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

Crown or core buildup, including pins

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

Abutment supported crown

Implant supported crown

Abutment supported retainer for fixed partial denture

Implant supported retainer for fixed partial denture

Implant/abutment supported removable denture for completely edentulous arch

Implant/abutment supported removable denture for partially edentulous arch

Implant/abutment supported fixed denture for completely edentulous arch

Implant/abutment supported fixed denture for partially edentulous arch

Dental implant supported connecting bar
Prefabricated abutment
Custom abutment

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

Surgical placement of implant body, endosteal implant
Surgical placement, eposteal implant
Surgical placement transosteal implant

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

GP-1-DNTL-90-16

P498.1083

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

GP-1-DNTL-90-16

P498.1086

Option B

Definitions

The terms that are italicized throughout this *plan*, are defined in this section.

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

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

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

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.

GP-1-DGY2K-D1

P498.0009

Option B

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

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

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.

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*.

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*.

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.

GP-1-DGY2K-D2

P498.0014

Option B

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

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*.

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.

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

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

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

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

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.

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

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

GP-1-DGY2K-D3

P498.0017

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.

GP-1-DISCOUNTS-11

P499.0088

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.

GP-1-DISCOUNTS-11

P499.0089

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.

GP-1-DISCOUNTS-11

P499.0090

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.

GP-1-DISCOUNTS-11

P499.0091

Option B

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.

GP-1-SERDIS-07-NY

P499.0081

Option B

COORDINATION OF BENEFITS

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.

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.

GP-1-R-COB-09-NY

P555.0301

Option B

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.

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.

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.

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.

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.

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.

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.

GP-1-R-COB-09-NY

P555.0302

Option B

ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00433322-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY

(herein called the Policyholder)

As of January 1, 2008, 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 judgement 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.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

Dated at _____ This _____ Day of _____ , _____

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY
Full or Corporate Name of Policyholder

Witness BY: _____
Signature and Title

The Guardian Life Insurance Company of America

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

This part of your plan is your Managed DentalGuard dental care expense insurance policy.

None of the following provisions apply to any of your other insurance coverages.

Option A

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
A Mutual Company - Incorporated 1860 by the State of New York
7 Hanover Square, New York, New York 10004
1-888-618-2016

**GROUP INSURANCE PLAN PROVIDING BENEFITS
FOR DENTAL CARE EXPENSES**

Planholder: WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY

Group Plan Number: 00433322

Delivered in: New York

Plan Effective Date: January 1, 2008

Plan Anniversaries: January 1st of each year, beginning in 2009.

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (referred to in this Plan as "Guardian," "us," "we," or "our"), in consideration of the application for this Plan and of the payment of premiums as stated herein, agrees to pay benefits in accordance with and subject to the terms of this Plan.

Premiums are payable by the Planholder as hereinafter provided. The first premium is due on the Plan Effective Date, and subsequent premiums are due, during the continuance of this Plan, the first day of each month.

This Plan is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Plan.

This Plan takes effect on the plan effective date specified above, and terminates on the last day of the month one year later if not renewed.

In witness whereof, The Guardian has caused this Plan to be executed as of July 1, 2019 which is its date of issue.

The Guardian Life Insurance Company of America

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

GP-1-MDG-NY1

P850.0453

Option A**PREMIUM RATES**

The monthly premium rates, in U.S. dollars, for the coverage provided under this Plan are as follows:

Option A Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
\$ 18.39	\$ 36.25	\$ 38.82	\$ 56.68

We have the right to change any premium rate(s) set forth at the times and in the manner established by the "Premiums" and "Adjustment of Premiums" sections of this Plan.

GP-1-MDGPREM-B

P850.0455

Option A

GENERAL PROVISIONS

Effective Date This Plan will: (a) be effective on the Plan effective date shown on the face page of this Plan; and (b) will continue until the last day of the month in which the termination of this Plan occurs. All coverage under the Plan will begin and end at 12:01 A.M., Eastern Time.

Premium Payments The first premium payment for this Plan is due on the Plan effective date. Further payments will be made on the first day of each month for each month this plan is in effect. You will pay Guardian the total sum indicated for each eligible Member. We may change such rates on the first day of any month. We must give You 31 days written notice of the rate change. Such change will apply to any premium due on or after the effective date of the change stated in such notice.

Limitation Of Authority 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 representation or by giving or receiving any information.

No change in this Plan will 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.

Entire Contract This Plan, including any amendments thereto and application, constitutes the entire agreement of the parties. This Plan may only be modified by a writing executed by the parties.

Incontestability This Plan will be incontestable after two years from its Effective Date, except for non-payment of Premiums.

No written statement in any application, except a materially fraudulent statement, made by a person insured under this Plan will be used in contesting the validity of his or her insurance or in denying a claim for a 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 material misrepresentations made in a signed application for up to two years from the Plan effective date.

GP-1-MDG-GP

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Associated Companies If You ask Us in writing to include an associated company under this Plan and We give our written approval, We will treat employees of that company as Your Employees. Our written approval will include the starting date of the company's coverage under this Plan. Each eligible employee of that company must still meet all of the terms and conditions of this Plan before he or she will be enrolled in the Plan.

You must notify Us in writing when a company stops being associated with Your company. On the date a company stops being an associated company, this Plan will end for all of that company's employees, except those employed by You or another covered associated company as eligible employees on such date.

Clerical Error - Misstatements Neither clerical error by You or Guardian in keeping any records pertaining to coverage under this Plan, nor delays in making entries thereon, will: (a) invalidate coverage otherwise in force; or (b) continue coverage otherwise validly terminated. Upon discovery of such error or delay, an equitable adjustment of premiums will be made.

If the age of a Member, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of fees will be made. If such misstatement involves whether or not a risk would have been accepted by Us, or the amount of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amount.

Statements No statement will void the coverage under this Plan, or be use in defense of any claim hereunder unless: (a) in the case of the Planholder, it is contained in the application signed by him or her; or (b) in the case of a Member, it is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

Employee's Certificate We will issue to You, for delivery to each Employee covered under this Plan, a Certificate of Coverage. The Certificate will state the essential features of the coverage to which the Employee is entitled and to whom the benefits are payable. The Certificate does not constitute a part of this Plan and will in no way modify any of the terms and conditions set forth in this Plan.

In the event this Plan is amended, and such amendment affects the material contained in the Certificate of Coverage, a rider or revised Certificate reflecting such amendment will be issued to You for delivery to affected Employees.

GP-1-MDG-4

P850.0457

Claims Of Creditors Except when prohibited by the laws of the jurisdiction in which this Plan was issued, the coverage under this Plan will be exempt from execution, garnishment, attachment or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Examinations 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.

Premiums You must pay Guardian the total sum indicated in the "Premium Rates" section of this Plan, per Member per month, commencing on the Plan effective date shown on the face page of this Plan. Payment will be made on the first day of the month for each month this Plan is in effect. You must pay premiums due under this Plan at an office of Guardian or to a representative that We have authorized.

You must arrange to collect any necessary Member contributions toward the premiums from the Members and pay the total premium on behalf of those Members. You agree to act as the agent for Your Members and not, under any circumstances, as an agent, employee or representative of Guardian in collecting any amount from such Members and paying it to Us. The initial premium is set forth on the application. The premium is paid by You, unless other provisions for payment are agreed to in advance by Guardian.

Adjustment Of Premiums The premiums due under this Plan on each due date will be the sum of each premium per Member covered by this Plan.

We may change such premiums: (a) on any date to the extent or terms of services provided to a Planholder are changed by amendment to this Plan; or (b) on any date Our obligation under this Plan with respect to You is changed because of statutory or other regulatory requirements.

Grace Period - Termination Of Plan A grace period of 31 days, without interest charge, will be granted to You for each premium except the first. If any premium is not paid before the end of the grace period, this Plan automatically terminates on the last day of the month to which the grace period applies. You will still owe us premiums for the month this Plan was in effect during the grace period.

Renewal Of Plan This Plan may be renewed on the Plan Anniversary date. You or Guardian may modify, amend or alter this Plan at renewal. Any such modification, amendment, alteration or renewal shall be: (a) agreed to by both parties in writing; and (b) attached to this Plan.

Records - Information To Be Furnished You will keep a record of covered Employees. Such record will contain, for each Employee, the essential particulars of coverage. You will periodically forward to Guardian, on Our forms, data concerning the Employees eligible for coverage under this Plan. We will direct You as to timing and format of such data. Such data will be that which may reasonably be considered to have a bearing on: (a) administration of the coverage under this Plan; (b) the determination of premiums; and (c) any other information which We may reasonably require.

GP-1-MDG-5

P850.0458

Option A

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures: Eligible Employees may enroll for dental coverage by: (a) filling out and signing an appropriate enrollment form and any additional material You may require during any open enrollment period; and (b) returning the enrollment material to You. You will forward it to Guardian. Thereafter, to obtain services the Member need only contact the selected and assigned Primary Care Dentist's office.

Guardian will issue each Member, either directly or through Your representative, a Managed DentalGuard (MDG) identification (ID) card, listing the name, address and telephone number of the selected and assigned Primary Care Dentist (PCD).

You will send a copy of the billing/eligibility list to Guardian by the 20th day of the current month. The list will: (a) state any changes to the current listing of Members to be covered for that month; and (b) specifically identify the data which follows:

- (1) Members newly eligible to receive services;
- (2) Members who are no longer eligible to receive services;
- (3) Whether the Employee's coverage is single or includes Dependents; and
- (4) Members' social security numbers or other identification numbers.

Open Enrollment Period: If the Employee does not enroll for dental coverage under this Plan within 30 days of becoming eligible, he or she 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 the Plan effective date, or at time intervals mutually agreed upon by You and Guardian.

Enrollment is for a minimum of twelve (12) consecutive months while a Member is eligible. Voluntary termination from this Plan will only be permitted during the open enrollment period.

If, after initial enrollment, a Member disenrolls from the Plan during an open enrollment period, he or she may not re-enroll until the open enrollment period which occurs after he or she has been without coverage for one (1) full year.

Changes in Member Status: If a Member is terminated or is no longer employed by You: (a) he or she will continue to be eligible to receive services; and (b) Guardian will be entitled to its monthly premium for the Member until such time that: (i) We are notified in writing of the Member's termination; and (ii) the Member is removed from the eligibility listing specified above.

SHOULD GUARDIAN BE NOTIFIED OF A MEMBER'S TERMINATION AFTER THE 10th DAY OF THE MONTH FOLLOWING THE MONTH OF TERMINATION, WE WILL RETAIN OR MUST BE PAID THE PREMIUM FOR THE MONTH IN WHICH THE MEMBER'S TERMINATION WAS REPORTED.

When Coverage Starts: Coverage starts on the date shown on the face page of this Plan for all Members enrolled on or before the Plan effective date. Coverage for a new Member starts on: (a) the first day of the month following the date enrollment materials were received by Us; or (b) the first day of the month after the end of any waiting period You may require.

When Dependent Coverage Starts: Except as stated below, Dependents will be eligible for coverage on the later of: (a) the date the Employee is eligible for coverage; or (b) the first day of the month following the date on which the Employee acquires 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 of placement in the home. If a newborn child, adopted child or foster child becomes covered under this Plan, the Employee must complete enrollment materials for such Dependent within 30 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 30 days.

When Coverage Ends: Subject to any continuation of coverage privilege which may be available to a Member, a Member's coverage under this Plan ends when the Employee's coverage terminates. A Member's coverage also ends on the first to occur of:

- (1) The end of the period for which the last premium payment is made for a Member;
- (2) The end of the month in which the Member ceases to be eligible for coverage under this Plan;
- (3) The end of the month in which a Dependent is no longer a Dependent as defined in this Plan;
- (4) The date on which the Member no longer resides or works in the Service Area;
- (5) The end of the 45 day period in which an Employee fails to pay any required Patient Charge for dental services rendered to the Employee or his or her Dependent, after advance written notice has been sent to the Employee of such failure to pay;
- (6) The date of entry of a Member into 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 a Member: (a) has knowingly given false information in writing on his or her enrollment form; or (b) has misused his or her ID card or other documents provided to obtain benefits under this Plan;
- (8) 30 days after written notice is sent to the Member advising that his or her 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 You 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 mental 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.

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 treatment 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.

Option A

CONTINUATION OF COVERAGE

Members may be eligible to retain coverage under this Plan during any Continuation of Coverage period or election period, necessary for the 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 a Member, provided the Employer continues to certify the eligibility of the Member and the monthly premiums for COBRA coverage for Members continue to be paid by or through the Employer pursuant to this Plan.

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to this Plan. The Member must contact the Employer to find out if:

- (a) the Employer is subject to the "Federal Continuation Rights" section, and therefore;
- (b) the section applies to the Member.

Federal Continuation Rights

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. 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 of the Employer; (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 An Employee's Group Dental Benefits End: If an Employee's group dental benefits end due to termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months if: (a) he or she was not terminated due to gross misconduct; (b) he or she is not covered for benefits from any other group plan at the time his or her group dental benefits under this Plan would otherwise end; and (c) he or she is not entitled to Medicare.

The continuation: (a) may cover the Employee and 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 XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to the Employee's 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.

To elect the extra 11 months of continuation, the qualified continuee must give You 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 You within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends".

This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from the qualified continuee by You during this extra 11 month continuation period.

If An Employee Dies While Insured: If an Employee dies 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".

If An Employee's Marriage Ends: If an Employee's 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".

If A Dependent Loses Eligibility: If a Dependent's group dental benefits end due to his or her loss of Dependent eligibility as defined in this Plan, other than Employee's coverage ending, he or she may elect to continue such benefits. But, such dependent 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 dental benefits due to: (a) the Employee's termination of employment; or (b) reduction of the Employee's work hours, the dependent 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 Dependent becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (ii) the Employee becomes entitled to Medicare.

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.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this section must notify You, in writing, of: (a) the legal divorce or legal separation of the Employee from his or her spouse; or (b) the loss of Dependent eligibility, as defined in this Plan, of a Dependent.

Such notice must be given to You within 60 days of either of these events.

The Planholder's Responsibilities: You 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 dental benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies You, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of a Dependent.

The Planholder's Liability: You will be liable for the qualified continuee's continued group dental benefits to the same extent as, and in place of, Us if: (a) You fail 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) You fail to notify the qualified continuee of his or her continuation rights, as described above.

Option A

Election Of Continuation: To continue his or her group dental benefits, the qualified continuee must give You 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 You 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 You, by the qualified continuee, in advance, at the times and in the manner You specify. 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 dental benefits had the qualified continuee stayed enrolled in the group plan on a regular basis. It includes any amount that You would have paid. Except as explained in "Extra Continuation for Disabled Qualified Continuees," You may also require an additional charge of 2% of the total premium charge.

If the qualified continuee: (a) fails to give You 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.

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

- (a) with respect to continuation upon the Employee's 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 dental 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 a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (c) with respect to continuation upon the Employee's death, the Employee's 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 the Employee's 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.

Option A

DENTAL EXPENSE COVERAGE

This Plan will cover many of a Member's dental expenses. 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.

Managed DentalGuard - This Plan's Dental Coverage Program

Managed DentalGuard (MDG): 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 Service Area. A "Participating Dentist" is a Dentist that has a MDG participation agreement in force with Guardian.

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. Read this Plan carefully for specific benefit levels, exclusions, limitations and Patient Charges.

Members can call Our Member Services Department if they have any questions after reading the material in the Certificate of Coverage.

Choice Of Dentists: A Member may select any available Participating General Dentist as his or her PCD. A request to change a PCD 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.

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, including 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 Plan.

Right to Reassign Member: If: (a) the Dentist a Member has selected is no longer a Participating Dentist in the MDG network; or (b) We take an administrative action which impacts the Dentist's participation in the network, We may have to assign the Member to a different Participating Dentist. In the event that this occurs, We will send a written notice to the Member within 15 days. The Member will have the opportunity to choose another Participating Dentist from among those in the MDG network. If a Member has a dental procedure in

progress when reassignment becomes necessary, Guardian will, at the Member's 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 applicable Plan provisions; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service. We will send the Member written notice when We are aware that a Participating Dentist is no longer available to treat the Member. This will be done within fifteen (15) days from the date We become aware that he or she will no longer be available.

If We Fail To Pay Participating Dentist: In the event We fail to pay a Participating Dentist, the Member will not be liable to the Participating Dentist for any sums owed by Us.

Relationship Between You And Participating Dentists And Institutions: You understand that: (a) the operation and maintenance of the participating dental offices, facilities and equipment; and (b) the rendition of all dental services will be solely and exclusively under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) the supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment.

We will undertake to see that the services provided to Members by Participating Dentists will be performed in accordance with professional standards prevailing in the county in which each Participating Dentist practices.

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 Plan.

GP-1-MDG-DE-1-NY-FCW

P850.0463

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 given in the Covered Dental Charges section. This is the only form of compensation that Participating Specialist Dentists 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 specialty referral process stated below 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 Plan;
 - (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 Plan; 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 Plan.
- (5) A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

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 conditions which follow:

- (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.

GP-1-MDG-DE-2B-NY-FCW

P850.0465

Option A

Emergency Dental Services: Guardian provides for Emergency Dental Services 24 hours a day, 7 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 the Member is unable to reach his or her PCD in an emergency during normal business hours, he or she must contact MDG's Member Services Department for instructions. If the Member is not able 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, he or she 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 reasonably possible. We will reimburse the Member for the cost of the Emergency Dental Services, less any applicable 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 may seek care from any 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.

GP-1-MDG-EM

P850.0466

Option A

Grievance Process

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 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 Plan). 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 acknowledgment 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.
- (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 dental 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, fever, swelling, serious bleeding or severe discomfort; or (b) to prevent the imminent loss of teeth, and are covered services under the 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.

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 acknowledgment 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.

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.

Option A

Utilization Review and Utilization Review Appeal Process

Definitions: "Utilization Review (UR)" means the review 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

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.

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 URA 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.

Expedited URA 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.

Option A

External Appeal: A Member and/or his or her Dentist have the right to external appeal of a final adverse determination after exhausting our internal review processes. The Member or Dentist may request an external appeal of a final AD by our internal appeal process, when:

- (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 procedure; or (b) both the Member 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 a Member's Dentist has certified that the Member has a life-threatening or disabling condition or disease:
 - (a) for which standard dental services or procedures have been ineffective or would be medically inappropriate; or
 - (b) for which there does not exist a more beneficial standard dental service or procedure covered by the Plan; or
 - (c) for which there exists a clinical trial.

The Member's 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 the Member than any covered, standard dental procedure; or
- ii) a clinical trial for which The Member is 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 the Member a fee of up to \$50 per external appeal. This fee is refundable to the Member in the event the external appeal agent overturns Guardian's final adverse determination. Guardian will not require the Member to pay any such fee if such fee will pose a hardship to him or her, as determined by Guardian.

Following the decisions of the Dentist reviewer, the Member 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.

Option A**Covered Dental Services And Patient Charges - Plan 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
Appointments and Diagnostic Services		
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	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
Radiographs		
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
Preventive & Space Maintenance		
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
Restorative		
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
2140	Amalgam - one surface - permanent	\$17.00
2150	Amalgam - two surfaces - permanent	\$22.00
2160	Amalgam - three surfaces - permanent	\$26.00
2161	Amalgam - four or more surfaces - permanent	\$32.00
2210	Silicate cement - per restoration	\$15.00
2330	Resin/composite - one surface, anterior	\$20.00
2331	Resin/composite - two surfaces, anterior	\$26.00

MDG Codes+	Description of Service	Patient Charge
	Restorative (Cont.)	
2332	Resin/composite - three surfaces, anterior	\$32.00
2335	Resin/composite - four or more surfaces or incisal angle, anterior	\$38.00
2336	Composite resin crown, anterior - primary	\$95.00
2380	Resin/composite - one surface, posterior - primary	\$55.00
2381	Resin/composite - two surfaces, posterior - primary	\$65.00
2382	Resin/composite - three or more surfaces, posterior - primary	\$80.00

+ 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 patient charge for the actual cost of the high noble metal used.

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Option A

MDG Codes+	Description of Service	Patient Charge
	Restorative (Cont.)	
2385	Resin/composite - one surface, posterior - permanent	\$56.00
2386	Resin/composite - two surfaces, posterior - permanent	\$75.00
2387	Resin/composite - three or more surfaces, posterior - permanent	\$95.00
	Crown, Bridge & Other Cast Restorations	
2510	Inlay - metallic - one surface*	\$280.00
2520, 6520	Inlay - metallic - two surfaces*	\$320.00
2530, 6530	Inlay - metallic - three or more surfaces*	\$370.00
2543, 6543	Onlay - metallic - three surfaces*	\$380.00
2544, 6544	Onlay - metallic - four or more surfaces*	\$395.00
2702	Crown supporting existing partial denture - in addition to crown	\$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	\$125.00
2740	Crown - porcelain/ceramic substrate	\$395.00
2750, 2751, 2752	Crown - porcelain fused to metal*	\$395.00
2790, 2791, 2792	Crown - full cast metal*	\$395.00
2810, 6780	Crown - 3/4 cast metallic*	\$395.00
6210, 6211, 6212	Pontic - cast metal*	\$385.00
6240, 6241, 6242	Pontic - porcelain fused to metal*	\$385.00
6750, 6751, 6752	Crown - abutment - porcelain fused to metal*	\$395.00
6790, 6791, 6792	Crown - abutment - full cast metal*	\$395.00
	Other Restorative Services	
2910, 2920, 6930	Recementation inlay, crown, bridge	\$18.00
2930, 2931	Prefabricated stainless steel crown	\$110.00
2932	Prefabricated resin crown	\$135.00
2940	Sedative filling	\$17.00
2950, 6973	Core buildup, including any pins	\$100.00
2951	Pin retention - per tooth, in addition to restoration	\$22.00
2952, 6970	Cast post & core	\$155.00
2954, 6972	Prefabricated post & core	\$125.00
2960	Labial veneer (lamine) - chairside	\$295.00

MDG Codes+	Description of Service	Patient Charge
Endontics		
3110, 3120	Pulp cap	\$10.00
3220	Therapeutic pulpotomy	\$25.00
3310	Root canal - anterior	\$120.00
3320	Root canal - bicuspid	\$145.00
3330	Root canal - molar	\$370.00
3346	Root canal - retreatment - anterior	\$315.00
3347	Root canal - retreatment - bicuspid	\$370.00
3348	Root canal - retreatment - molar	\$445.00
3410	Apicoectomy/periradicular surgery - anterior	\$265.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	\$300.00
3425	Apicoectomy/periradicular surgery - molar - first root	\$350.00
3426	Apicoectomy/periradicular surgery - each additional root	\$110.00
3430	Retrograde filling - per root	\$80.00
Periodontics		
4210	Gingivectomy or gingivoplasty - per quadrant	\$235.00
4211	Gingivectomy or gingivoplasty - per tooth	\$60.00
4240	Gingival flap procedure - including root planing - per quadrant	\$275.00
4249	Clinical crown lengthening - hard tissue	\$275.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	\$392.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	\$235.00
4270	Pedicle soft tissue graft procedure	\$290.00
4271	Free soft tissue graft procedure (including donor site surgery)	\$298.00
4341	Periodontal scaling & root planing - per quadrant	\$40.00

+ 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 patient charge for the actual cost of the high noble metal used.

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Option A

MDG Codes+	Description of Service	Patient Charge
Periodontics (Cont.)		
4355	Full mouth debridement to enable evaluation and diagnosis	\$24.00
4910	Periodontal maintenance procedures (following active therapy)	\$22.00
4920	Unscheduled dressing change (by other than treating dentist)	\$19.00
9951	Occlusal adjustment - limited - per visit	\$20.00

MDG Codes+	Description of Service	Patient Charge
	Prosthodontics (Removable)	
5110, 5120	Complete denture (including routine post delivery care)	\$452.00
5130, 5140	Immediate denture (including routine post delivery care)	\$492.00
	Partial dentures (including routine post delivery care):	
5211	Upper Partial, Resin base - including clasps, rests, teeth	\$381.00
5212	Lower Partial, Resin base - including clasps, rests, teeth	\$443.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth	\$500.00
	Repairs and adjustments:	
5410, 5411, 5421, 5422	Denture adjustments	\$25.00
5510	Repair broken denture base	\$50.00
5520, 5640	Replace missing or broken teeth - per tooth	\$45.00
5610	Repair resin denture base	\$55.00
5630	Repair or replace clasp	\$70.00
5650	Add tooth to existing partial	\$65.00
5660	Add clasp to existing partial	\$80.00
5710, 5711, 5720, 5721	Rebase denture	\$200.00
5730, 5731, 5740, 5741	Reline denture (chairside)	\$110.00
5750, 5751, 5760, 5761	Reline denture (laboratory)	\$150.00
5820, 5821	Interim partial denture (stayplate)	\$175.00
5850, 5851	Tissue conditioning	\$45.00
	Oral Surgery	
7110, 7120	Extraction - single tooth	\$22.00
7130	Root removal - exposed roots	\$30.00
7210	Surgical removal of erupted tooth	\$90.00
7220	Removal of impacted tooth - soft tissue	\$115.00
7230	Removal of impacted tooth - partially bony	\$150.00
7240	Removal of impacted tooth - completely bony	\$180.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$225.00
7250	Surgical removal of residual tooth roots (cutting procedure)	\$95.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$210.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	\$230.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$195.00
7285	Biopsy of oral tissue - hard	\$125.00
7286	Biopsy of oral tissue - soft	\$85.00
7310	Alveoplasty in conjunction with extractions - per quadrant	\$105.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	\$140.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm	\$350.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm	\$540.00
7510	Incision & drainage of intraoral abscess	\$105.00
7960	Frenulectomy (separate procedure)	\$230.00

MDG Codes+	Description of Service	Patient Charge
	Miscellaneous Services	
9110	Palliative (emergency) treatment - per visit	\$20.00
9215	Local anesthesia	No Charge

+ 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 patient charge for the actual cost of the high noble metal used.

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Option A

MDG Codes+	Description of Service	Patient Charge
	Orthodontics	
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: dependent child to age 18 (as determined by the Member's 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: employee, spouse, or dependent child over age 18 (as determined by the Member's 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 by Participating Orthodontists in the State of New York.

GP-1-MDG-L4-NYA-FCW

P850.0480

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 either 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.

Multiple Crown/Bridge Unit Treatment Fee: A Member's approved treatment plan may include 6 or more 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 An Existing Partial Denture: A crown may be: (a) placed under an existing partial denture; and (b) customized to physically support the metal framework of the partial denture. In such case, the Member must pay the 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 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.

GP-1-MDG-GG-FCW

P850.1015

Orthodontic Treatment: 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 involving 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.

GP-1-MDG-ORTH-A-FCW 11/00

P850.1016

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.

GP-1-MDG-LMT-FCW

P850.0486

Option A

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.
- 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: (a) congenitally missing teeth; or (b) 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.
- Temporary or provisional restorations or prosthetic appliances, except those that are incidental to an ongoing course of prosthetic treatment.
- Any Member request for: (a) specialist services or treatment which can be routinely provided by the PCD; or 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 covered Emergency Dental Services.
- 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, crowns or 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.
- Procedures, appliances or devices: (a) to guide minor tooth movement; or (b) to correct or control harmful habits.
- 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

DEFINITIONS

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.

GP-1-MDG-D1

P850.0489

Associated Company means a corporation or other business entity affiliated with the Employer, through common ownership of stock or assets.

GP-1-MDG-D2

P850.0490

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.

GP-1-MDG-D3

P850.0491

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

- (1) the Employee's spouse; or
- (2) an unmarried Dependent child of either the Employee or the Employee's spouse who is:
 - (a) less than 20 years of age, or less than 26 if a full-time student; and
 - (b) primarily dependent upon the Employee or Employee's spouse for support and maintenance.

The term "Dependent Child" as used in this Plan includes any: (a) stepchild; (b) newborn child; (c) legally adopted child; (d) child for whom the Employee is 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 the Employee's household and is primarily dependent on the Employee for support and maintenance. The term also includes any child for whom a court-ordered decree requires the Employee 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 the Employee for support and maintenance. The Employee must furnish proof of such lack of capacity and dependence to Us within 31 days after the child attains 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 You offer, including this one.

GP-1-MDG-D4-C

P850.0494

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) to 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.

GP-1-MDG-D5

P850.0498

Employee means a person: (a) who meets the Planholder's eligibility requirements; and (b) for whom a Planholder makes monthly payments under this Plan.

GP-1-MDG-D6

P850.0499

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.

GP-1-MDG-D7

P850.0500

Member means an Employee and any of his or her eligible Dependents: (a) as defined under the eligibility requirements of this Plan; and (b) as determined by the Planholder, who are actually enrolled in and eligible to receive benefits under this Plan.

GP-1-MDG-D8

P850.0501

Non-Participating Dentist means any Dentist that does not have an MDG participation agreement in force with Us to provide services to Members.

GP-1-MDG-D9

P850.0502

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 such Dentist.

GP-1-MDG-D10

P850.0503

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.

GP-1-MDG-D11

P850.0504

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.

GP-1-MDG-D12-B

P850.0506

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.

GP-1-MDG-D13

P850.0507

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

GP-1-MDG-D14

P850.0508

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.

GP-1-MDG-D15

P850.0509

Service Area means the geographic area in which Guardian is licensed to provide for dental services for Members.

GP-1-MDG-D16

P850.0510

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

GP-1-MDG-D17

P850.0511

You, Your or Planholder means the Employer or other entity who purchased this Plan.

GP-1-MDG-D18

P850.0512

Option A

COORDINATION OF BENEFITS

Applicability

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, trusted 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 governmental 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 the Plan subject to this provision.

How This Provision Works: The Order of Benefits

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;
- (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 are determined before those of the parent whose birthday falls later in that year; but
 - (b) if both parents have the same birthday, the benefits of the plan which covered a parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
 - (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 with 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 covered person was eligible under the second within 24 hours after the first plan ended.

The Member's length of time covered under a 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.

How This Provision Works: Coordinating Benefits

Coordinating 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 PCD's 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 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.

GP-1-MDG-COB-NY

P850.0513

Coordinating 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.
- 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 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.

GP-1-MDG-COB-NY

P850.0514

Option A

Our Right To Certain Information

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.

GP-1-MDG-COB2

P850.0515

Option A

STATEMENT OF ERISA RIGHTS

As a participant, an employee is 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 insurance 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 the employee benefit plan. They have a duty to operate the Plan prudently and in the interest of plan participants and beneficiaries. An employer may not fire an employee or otherwise discriminate against him or her in any way to prevent him or her from obtaining a welfare benefit or exercising his or her rights under ERISA. If an employee's 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. An employee has the right to have his or her claim reviewed and reconsidered.

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

Guardian agrees 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 on the face page of this Plan.

Option A

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00433322-

issued by

The Guardian Life Insurance Company of America

7 Hanover Square
New York, NY 10004

to

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY

(herein called the Policyholder)

Effective on the later of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends Your Plan as follows:

The section of Your Policy entitled "When Coverage Ends" is replaced by the following:

When Coverage Ends: Subject to any continuation of coverage privilege which may be available to a Member, a Member's coverage under this Plan ends when the Employee's coverage terminates. A Member's coverage also ends on the first to occur of:

1. The end of the period for which the last premium payment is made for a Member;
2. For a Member, the end of the month in which the Member ceases to be eligible for coverage under this Plan;
3. For a Member's Dependent:
 - For a Dependent spouse, the end of the month in which a spouse is no longer a Dependent as defined in this Plan;
 - For a Dependent child, the end of the month in which a child is no longer a Dependent as defined in this Plan;
4. If a Member or his/her 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 a Member or his/her Dependent.

But, if a Member or his/her 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 a Members or his/her Dependents coverage will have a retroactive effect of up to your enrollment under the certificate.

If termination is a result of a Members action, coverage will terminate for the Member and his/her Dependents. If termination is a result of a Members Dependents action, coverage will terminate for the Dependent. changes necessary to avoid termination.

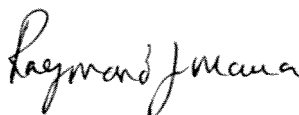
This rider is part of this Plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Plan.

Dated at _____ This _____ Day of _____, _____

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY
Full or Corporate Name of Policyholder

Witness BY: _____ Signature and Title

The Guardian Life Insurance Company of America



Raymond Marra, Senior Vice President, Group and Worksite Markets

GP-1-MDG-DENDEP-17-NY

P850.1295

* * * * *

The foregoing amendment shall form a part of said Group Policy, provided both the Policyholder and the Insurance Company have hereto applied their respective signatures, and is subject to the agreements and covenants therein contained.

Dated at Bethlehem, PA This 1st Day of July, 2019

WEILL CORNELL MEDICAL COLLEGE OF CORNELL UNIVERSITY
Full or Corporate Name of Policyholder

Witness BY: _____ Signature and Title

The Guardian Life Insurance Company of America

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

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

GUR-1

P600.9002

END OF POLICY DOCUMENT

