YOUR GROUP INSURANCE PLAN BENEFITS

MARCHESE FORD OF MECHANICVILLE
CLASS 0001
DENTAL

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

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

This Booklet Includes All Benefits For Which You Are Eligible.

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

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

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

The group dental expense coverage described in this Certificate is attached to the group Policy effective September 1, 2016. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the planholder by Guardian.

GROUP DENTAL EXPENSE COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

The insurance evidenced by this Certificate provides DENTAL insurance only.

Policyholder: MARCHESE FORD OF MECHANICVILLE

Group Policy Number: 00529922

The Guardian Life Insurance Company of America

Michael Estep, Vice President

B034.2476

GC-DEN-13-NY

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All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B034.2475

All Options

Active Work or Actively At Work: These terms mean Your performance of all the duties that pertain to Your work at the place: (1) where it is normally done; or (2) where it is required to be done by Your Employer

Anterior Teeth: This term means the incisor and cuspid teeth. These are the teeth located in front of the bicuspids (pre-molars).

Appliance: This term means any dental device other than a Dental Prosthesis.

B034.2487

All Options

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

All Options

Covered Dental Specialty This term means any group of procedures which falls under one of the following categories, whether performed by a specialist Dentist or a general Dentist: (1) restorative/prosthodontic services; (2) endodontic services; (3) periodontic Services; (4) oral surgery; and (5) pedodontics.

Covered Family: This term means You and those of Your dependents who are covered by this Plan.

Covered Person: This term means You, if You are covered by this Plan, and any of Your covered dependents.

B034.2489

All Options

Dental Prosthesis This term 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: (1) abutment crowns; (2) inlays and onlays; (3) bridge pontics; (4) complete and immediate dentures; (5) partial dentures; and (6) and unilateral partials. It also includes all types of: (a) crowns; (b) veneers; (c) implants; and (d) posts and cores.

Dentist: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Plan.

B034.2490

All Options

Eligibility Date: For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan. For dependent coverage, this term means the earliest date on which: (1) You have initial Dependents; and (2) are eligible for dependent coverage.

Emergency Treatment: This term means bona fide emergency services which: (1) 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 (2) are covered by this Plan.

Employee: This term means a person who works for the Employer and whose income is reported for tax purposes using a W-2 form.

Employer: This term means MARCHESE FORD OF MECHANICVILLE .

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B034.2498

All Options

Full-time: This term means You 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: (1) Your Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B034.2502

All Options

Initial Dependents: This term means those eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your initial dependents.

Injury: This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Plan; and (2) all complications arising from that damage. But, the term does not include damage to teeth, Appliances or dental prostheses which results solely from chewing or biting food or other substances.

B034.2504

All Options

Late Entrant: This term means a person who: (1) becomes covered by this Plan more than 31 days after he or she is eligible; or (2) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

B034.2518

All Options

Newly Acquired Dependent: This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

Non-Preferred Provider: This term means a Dentist or dental care facility that is not under contract with DentalGuard Preferred as a Preferred Provider.

B034.2519

All Options

Orthodontic Treatment This term means the movement of one or more teeth by the use of Active Appliances. It includes: (1) treatment plan and records, including initial, interim and final records; (2) periodic visits, (3) limited Orthodontic Treatment, interceptive Orthodontic Treatment and comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances; (4) orthodontic retention, including any and all necessary fixed and removable Appliances and related visits.

B034.2522

All Options

Payment Limit: This term means the maximum amount this Plan pays for covered charges for covered services during a Benefit Year.

Payment Rate: This term means the percentage rate that this Plan pays for covered charges for covered services.

Plan: This term means the group dental expense coverage described in the Policy and this Certificate.

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

Preferred Provider: This term means a Dentist or dental care facility that is under contract with DentalGuard Preferred as a Preferred Provider.

Prior Plan: This term means the Employer's plan of group dental coverage which was in force immediately prior to this Plan. For a plan to be considered a Prior Plan, the Guardian Plan must start immediately after the prior coverage ends.

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

B034.2525

All Options

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

You or Yours: These terms mean the insured of the Employee.

B034.2532

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. In the event that the Certificate includes such multiple benefit options and types of benefits, each Covered Person will only be covered for those applicable benefits that (1) were previously selected in a manner and mode acceptable to Guardian such as an enrollment form and (2) for which applicable premium has been received by Guardian.

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

Incontestability

The Plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred, after such insurance has been in force for two years during his or her lifetime.

If the Plan replaces a plan Your Employer had with another insurer, We may rescind the Plan based on misrepresentations made by the Employer or an Employee signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

B034.2553

CLAIM DETERMINATIONS

Claims

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Preferred Provider, You will not need to submit a claim form. However, if You receive services from a Non-Preferred Provider either You or the Provider must file a claim form with Us. If the Non-Preferred Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

Notice of Claim

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling 888-618-2016 or visiting Our website at guardiananytime.com. Completed claim forms should be sent to the address on Your ID card. Effective on the date of issuance or renewal of this Certificate on or after April 1, 2015, You may also submit a claim to Us electronically by visiting Our website at guardiananytime.com.

Timeframe for Filing Claims

Claims for services must be submitted to Us for payment within 180 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 180 day period, You must submit it as soon as reasonably possible. In no event, except in the absence of legal capacity, may a claim be filed more than one (1) year from the time the claim was required to be filed.

Claims for Prohibited Referrals

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

Claim Determinations

Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials and Referrals. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

Pre-Service Claim Determinations

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three (3) calendar days of the decision.

Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

All Options

ELIGIBILITY FOR DENTAL COVERAGE - EMPLOYEE COVERAGE

B034.2556

All Options

Eligible Employees

Subject to the conditions of eligibility set forth below, and to all of the other conditions of the Plan, You are eligible if You are in an eligible class of Employees and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet the Plan's conditions of eligibility.

Conditions of Eligibility

You are eligible for dental coverage if You are regularly working at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

B034.2575

All Options

Once each year, during the group enrollment period You may elect to enroll in the dental expense plan offered by Your Employer. Coverage starts on the first day of the month that next follows the date of enrollment. You and Your eligible dependents are not subject to late entrant penalties if you enroll during the group enrollment period.

As used here, "group enrollment period" means an annual open enrollment period set by Your Employer and agreed to by Us.

B034.2580

All Options

When Employee Coverage Starts

You must be Actively At Work and working Your regular number of hours on the date Your coverage is scheduled to start. And, You must have met all of the conditions of eligibility which apply to You. If You are not Actively At Work, We will postpone the start of Your coverage until You return to Active Work.

The date Your coverage is scheduled to start is determined as shown below:

If You do not have to pay any of the cost of Your coverage, Your coverage is scheduled to start on Your Eligibility Date, subject to all the terms of this Plan.

Sometimes a scheduled effective date is not a regularly scheduled work day. This means: (1) a holiday; (2) a vacation day; or (3) a non-scheduled work day. In that case, Your coverage is scheduled to start if, on Your last regularly scheduled work day, You were: (a) Actively At Work; and (b) working Your regular number of hours.

B034.2588

All Options

When Employee Coverage Ends

Your coverage will end on the first of the following dates:

The last day of the month in which Your active full-time service ends for any reason. Such reasons include: (1) disability; (2) retirement; (3) layoff; (4) leave of absence; and (5) the end of employment.

The last day of the month in which You stop being an eligible Employee under this Plan.

The date the group Plan ends, or is discontinued for a class of Employees to which You below.

The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverages would otherwise end. Read this Plan carefully for details.

B034.2593

All Options

ELIGIBILITY FOR DENTAL EXPENSE COVERAGE - DEPENDENT COVERAGE

B034.2605

All Options

Eligible Dependents For Dental Expense Coverage

Your eligible dependents are Your: (a) spouse; and (b) Your dependent children who are under age 26.

Spouse means the lawful spouse of the covered employee. The term also includes the marriage between same-sex partners legally performed in other jurisdictions.

B034.2608

All Options

Newborn, Adopted Children And Step-Children

Your dependent children include any newborn infants, including newly born infants adopted by You if the You take physical custody of the infant upon the infant's release from the hospital and files a petition pursuant to the domestic relations law within 30 days of birth; and provided further that no notice of revocation to the adoption has been filed and consent to the adoption has not been revoked, shall be effective from the moment of birth, except that in cases of adoption, coverage of the initial hospital stay shall not be required where a birth parent has insurance coverage available for the infant's care.

Adopted children and stepchildren who are dependent upon You are eligible for coverage on the same basis as natural children. A proposed adoptive parent, on whom the child is dependent, such child shall be eligible for coverage on the same basis as a natural child during any waiting period prior to the finalization of the child's adoption.

B034.2610

All Options

Dependents Not Eligible

We exclude any dependent who is covered by this Plan as an Employee.

B034.2611

Handicapped Children

You may have an unmarried disabled child regardless of age: who is: (a) incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation, as defined in the mental hygiene law, or physical handicap, and who became so incapapable prior to attainment of the age at which dependent coverage would otherwise end; and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent dental benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she remains: (i) incapable of self-sustaining employment; and (ii) dependent upon You for most of his or her support and maintenance.
- You send us written proof, and we approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

The child's coverage ends when Your coverage ends.

B034.2612

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for Your dependents under this Plan because they were covered under another group dental plan and You now elect to enroll them in the dental coverage under this Plan, they will not be considered Late Entrants if their dental coverage under the other plan ends due to one of the events listed below:

- Termination of Your spouse's employment.
- Loss of eligibility under Your spouse's dental plan.
- Divorce.
- Death of your spouse.
- Termination of the other dental plan.
- Any other event as required by state or federal law or in accordance with Your Employer's rules.

GC-DEN-13-NY

But, You must enroll Your dependents in the dental coverage under this Plan within 30 days of the date that any of the events listed above occurs.

And, Your dependents will not be considered Late Entrants if: (1) You are under legal obligation to provide dental coverage due to a court-order; and (2) You enroll them in this plan within 30 days of the issuance of the court-order.

B034.2613

All Options

When Dependent Coverage Starts

In order for your dependent coverage to begin You must already be covered for Employee coverage or enroll for Employee and dependent coverage at the same time.

Subject to the Exception below and to all of the terms of this Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

If You do this on or before your Eligibility Date, the dependent's coverage is scheduled to start on the later of the first day of the month which coincides with or next follows Your Eligibility Date and the date You become insured for Employee coverage.

If you do this within the Enrollment Period, the coverage is scheduled to start on the date You become insured for Employee coverage.

If you do this after the Enrollment Period ends, each of Your Initial Dependents is a Late Entrant and is subject to any applicable Late Entrant Penalties. Such dependent's coverage is scheduled to start on the first day of the month which coincides with or next follows the date You sign the enrollment form.

Once you have dependent coverage for Your Initial Dependents, You must notify Us when You acquire any new dependents and agree to make any additional payments required for their coverage.

A Newly Acquired Dependent will be covered from the later of the date You notify Us and agree to make any additional payments, and the date the Newly Acquired Dependent is first eligible. But, You must notify Us and agree to make any additional payments within 31 days after the date he or she becomes eligible. If You do this more than 31 days after the date the Newly Acquired Dependent becomes eligible, he or she will be covered from the date You notify Us and agree to make any additional payments. And, such dependent is a Late Entrant and is subject to any applicable Late Entrant penalties.

B034.2618

All Options

Newborn Children We cover Your newborn child for dependent benefits from the moment of birth if: (1) You are already covered for dependent child coverage when the child is born; or (2) You enroll the child and agree to make any required premium payments within 30 days of the date the child is born. If You fail to do this, once the child is enrolled, he or she: (a) is a Late Entrant; (b) is subject to any applicable Late Entrant penalties; and (c) will be covered as of the later of the first day of the month which coincides with or next follows the date You sign the enrollment form.

B034.2620

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when Your Employee coverage ends. Dependent coverage also ends for all of Your dependents when You stop being a member of a class of Employees eligible for such coverage. And, it ends when this Plan ends, or when dependent coverage is dropped from this Plan for all Employees for Your class.

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

Your dependent's coverage ends when he or she stops being an eligible dependent. This happens to Your child on the last day of the month in which Your child attains the age limit, or for Your handicapped child who has reached the age limit, when he or she marries, or is no longer dependent upon You for support and maintenance. It happens to a spouse on the last day of the month in which Your marriage ends in legal divorce or annulment.

B034.2623

All Options

DENTAL EXPENSE INSURANCE

This coverage 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.

This Certificate includes form(s) GC-SCH-DEN-13-NY, which are the Plan's Schedule of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You. See form(s) GC-SCH-DEN-13-NY.

B034.2627

All Options

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, this Plan requires a Covered Person to seek dental care from Dentists and dental care facilities that are under contract with Guardian's dental preferred provider organizations (PPOs), 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. When You enroll in this Plan, You and Your covered dependents receive: (1) a dental plan ID card; and (2) information about current Preferred Providers.

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.

A Covered Person must either present his or her ID card or supply the group number and member ID 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 Guardian at the number shown on his or her ID card should he or she have any questions about this Plan.

B034.2636

Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

B. Filing a Grievance.

You can contact Us by phone at 1-888-618-2016 or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You in writing within the following timeframes:

Expedited/Urgent Grievances: By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.) In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances: (A claim for a service or a treatment that has already been provided.) In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim or request for a service.) In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at 1-888-618-2016 or in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of 2 business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.) 15 calendar days of receipt of Your Appeal.

Post-Service Grievances: (A claim for a service or a treatment that has already been provided.) 30 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation to a claim or request for a service.) 30 calendar days of receipt of Your Appeal.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
www.communityhealthadvocates.org

B034.2639

All Options

Utilization Review

A. Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call 1-888-618-2016 or the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) by licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Health Care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, call 1-888-618-2016 visit Our website at www.guardiananytime.com.

B. Preauthorization Reviews

1. If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) Business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

C. Concurrent Reviews.

1. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within one (1) business day of the end of the 45-day time period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour time period.

D. Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

B034.2640

All Options

E. Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration

If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the Appeal

H. Standard Appeal

Preauthorization Appeal. If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request

Retrospective Appeal. If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeal. An Appeal of review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Appeal Assistance.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
105 East 22nd Street
New York, NY. 10010
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
www.communityhealthadvocates.org

B034.2641

All Options

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate; and

- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing Requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right To Appeal A Determination That A Service is Not Medically Necessary

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment, (including clinical trials and treatments for rare diseases). You must satisfy the two requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation - Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

B034.2642

All Options

D. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external 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 Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Certificate. 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 cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agents decision is binding on both You and Us. The External Appeal Agents decision is admissible in any court proceeding.

We will charge You a fee of up to $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

E. Your Responsibilities

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

Covered Charges

If a Covered Person uses the services of a Preferred Provider for dental services listed in this Plan's List of Covered Dental Services, covered charges are the lesser of: (1) the Preferred Provider's submitted charge, (2) the amount listed in the Preferred Provider's contracted fee schedule applicable to the particular dental covered service, and (3) if the Preferred Provider has agreed to a contracted percentage discount applicable to the particular dental covered service, the lesser of: (a) the amount calculated based on the contracted percentage discount of the Preferred Provider's submitted charge and (b) the reasonable and customary charges for the dental service. Preferred Providers agree to accept such charges as payment in full for the applicable dental covered services. In the event that a specific fee schedule amount or contracted percentage does not exist for a covered service, covered charges are the lesser of: (1) the Preferred Provider's submitted charge and (2) the reasonable and customary charges for the dental service.

In the event that (a) a benefit for a covered service is determined in accordance with the Alternate Treatment provision, and (b) the Preferred Provider has agreed to a contracted percentage discount amount for such Alternate Treatment, covered charges are the amount calculated as follows:

(the amount calculated based on the contracted percentage discount of the Preferred Provider's submitted charge) multiplied by (the national mean of the fee for the Alternate Treatment procedure divided by the national mean of the fee for the submitted procedure).

If a covered person uses the services of a Non-Preferred Provider, covered charges for the submitted procedure or, if the Alternate Treatment provision is applied, the Alternate Treatment procedure are the lesser of: (a) the Non-Preferred Provider's submitted charges; and (b) the most prevalent fee schedule amount a preferred provider has agreed to accept as payment in full used in that geographical area, 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.

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

B034.2645

All Options

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. The denial of the requested service is treated as an adverse determination, and is subject to internal and external appeal rights contained in the Grievance Procedures and External Appeal Sections.

Proof of Claim

The Covered Person or his or her Dentist must provide Us with proof that is acceptable to Us. This proof 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 do not receive the necessary proof, We may pay no benefits, or minimum benefits. But, if We receive the necessary proof within 15 months of the date of service, We will redetermine the Covered Person's benefits based on the new proof.

B034.2671

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 Us. The treatment plan must include: (1) a list of the services to be done, using the American Dental Association Nomenclature and codes; (2) the itemized cost of each service; and (3) 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 his or her 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: (1) the services being performed as proposed and while the person is covered; and (2) the benefit provisions, and all of the other terms of this Plan.

Emergency Treatment, oral exams, 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 will not 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.

B034.2673

Benefits From Other Sources

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

B034.2674

Penalty For Late Entrants

During the first 6 months that a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group II services.

During the first 12 months that a Late Entrant is covered by this Plan, We will not cover charges for the following services:

- Group III services.

Charges We do not cover as shown above are not covered charges under this Plan, and cannot be used to meet this Plan's deductibles.

We do not apply a Late Entrant penalty to covered charges incurred for services needed solely due to an Injury suffered by a person while covered by this Plan.

B034.2722

All Options

How We Pay Benefits For Covered Dental Services

Deductible: We pay benefits for covered charges for dental services which exceed the Benefit Year deductible.

The Benefit Year deductibles shown in the Schedule Of Benefits, apply to Covered Dental Services. Each Covered person must have covered charges which exceed the deductible before We pay him or her any benefits for such charges. These charges must be incurred while he or she is covered.

Covered charges used to satisfy a Covered Person's Non-PPO deductible are also credited towards his or her PPO deductible. And, covered charges used to satisfy a Covered Person's PPO deductible are also credited towards his or her Non-PPO deductible.

B034.2772

All Options

Family Deductible Limit: A Covered Family must meet no more than three individual deductibles in any Benefit Year.

B034.2774

All Options

Payment Of Benefits Once the deductible is met, We pay benefits for Covered Dental Services covered charges above that amount at the applicable Payment Rates for the rest of that Benefit Year. This Plan's Payment Rates are shown in the Schedule Of Benefits.

B034.2788

All Options

What We pay for is subject to the Benefit Year Payment Limit shown in the Schedule of Benefits and to all of the terms of this Plan.

After This Coverage Ends We do not pay for charges incurred after a person's coverage ends. But, subject to all of the other terms of this Plan, We will pay for the completion of a dental procedure that was started before the Covered Person's coverage ended, if the procedure is finished in the 30 days after a person's coverage under this Plan ends.

B034.2784

EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Certificate for the following:

A. Aviation.
We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.
We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Cosmetic Services.
We do not Cover cosmetic services, Prescription Drugs or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Certificate unless medical information is submitted.

D. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

E. Dental Services. We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

F. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical Trial as described in the Outpatient and Professional Services section of this Certificate, or when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

G. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

H. Foot Care.
We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

I. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

J. Medically Necessary.
In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

K. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

L. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

M. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

N. Services not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

O. Services Provided by a Family Member.
We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister, or brother of You or Your Spouse.

P. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Q. Services With No Charge.
We do not Cover services for which no charge is normally made.

R. Vision Services.
We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Vision Care section of this Certificate.

S. War.
We will not Cover an illness, treatment, or medical condition due to war, declared or undeclared.

T. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

B034.2726

All Options

LIST OF COVERED DENTAL SERVICES

The services covered by this Plan are named in this list. Additional services that are not named on this list may also be eligible for coverage. In order to be covered, the service must be furnished by, or under the direct supervision of, a Dentist. And, it must be usual and necessary treatment for a dental condition.

Covered dental services do not include the use of local anesthesia or prescription medication. Covered dental services do not include any endodontic, periodontal, crown or bridge abutment procedure or Appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

B034.2741

All Options

Group I Services

Prophylaxis And Fluorides: Prophylaxis (Adult prophylaxis covered age 12 and older): Limited to a total of 1 prophylaxis or periodontal maintenance in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains. "Also see Periodontal Maintenance under Group II Services."

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, 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 Covered Person’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.

B034.2756

All Options

Fluoride treatment, topical application: Limited to Covered Persons under age 19 and to 1 treatment(s) in any 6 consecutive month period.

B034.2768

All Options

Office Visits, Evaluations And Examination Comprehensive oral evaluations - limited to once every 36 months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of 1 in any 6 consecutive month period.

B034.2791

All Options

Limited oral evaluation - problem focused or emergency oral evaluation: Limited to a total of 1 in any 6 consecutive month period. Covered only when no other treatment, other than radiographs, is performed in the same visit.

B034.2792

All Options

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

B034.2793

All Options

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.

Removal of fixed space maintainer is considered once per quadrant or arch (as applicable) per lifetime.

B034.2794

All Options

Fixed And Removable Appliances: Fixed and Removable Appliances to inhibit thumb sucking: Limited to Covered Persons under age 14 and limited to initial Appliance only. Allowance includes all adjustments in the first six months after insertion.

B034.2795

All Options

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 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.
- Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.
- Intraoral periapical or occlusal images - single images.

B034.2801

All Options

Dental Sealants: Dental Sealants or Preventive Resin Restoration, permanent molar teeth only: Topical application of sealants is limited to the unrestored, caries free, permanent molar teeth of Covered Persons under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

B034.2804

All Options

Group II Services

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. This dental Plan covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

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: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

Restorative Services Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be considered if at least 12 months have passed since the previous restoration was placed if the Covered Person is under age 19, and 36 months have passed since the previous restoration was placed if the Covered Person is age 19 and older. Also see Group III Restorative Services.

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.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 24 consecutive month period. Prefabricated 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.

B034.2817

All Options

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.

Pulpotomy: Only when root canal therapy is not the definitive treatment.

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.
- 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

B034.2829

All Options

Periodontal Services Periodontal Maintenance: Periodontal maintenance: Limited to a total of 1 prophylaxis or periodontal maintenance in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. Also see Prophylaxis under Prophylaxis And Fluorides in Group I Services.

Periodontal Services Other than Maintenance: 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.

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.

B034.2838

All Options

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. Considered when performed to retain teeth.

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

- Gingivectomy or gingivoplasty, per tooth (less than three teeth).
- Crown lengthening, hard tissue.

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

- 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 treatment listed below is limited to a total of one of the following, once per quadrant in any 36 consecutive month period, when the tooth is present, or when dentally necessary as part of the a covered surgical placement of an implant.

- Pedicle or free soft tissue grafts, including donor site.
- Subepithelial connective tissue graft procedure.

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

- Guided tissue regeneration, resorbable barrier or nonresorbable barrier.
- Bone replacement grafts.

Periodontal Surgery Related: Limited occlusal adjustment: Limited to a total of two visits, covered only when done within a six consecutive month period after covered scaling and root planing or osseous surgery.

Occlusal guards: Covered only when done within a six consecutive month period after osseous surgery, and limited to one per lifetime.

B034.2839

All Options

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 Employer's 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 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 Employer's 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.
Brush biopsy.
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.

B034.2847

All Options

Other Services: General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, 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 Surgical Procedures.

Injectable antibiotics needed solely for treatment of a dental condition.

B034.2849

All Options

Group III Services

Group III 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. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or Injury. 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. During the first 12 months that a Covered Person is covered by this Plan We do not cover charges for a Dental Prosthesis which replaces such teeth unless the Dental Prosthesis also replaces one or more eligible natural teeth lost or extracted after he or she became covered by this Plan. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Temporary Appliances older than one year are considered be a permanent Appliance. Limited to permanent teeth only.

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 connection 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. The number of implants We cover is limited to the number of teeth extracted in the same area while the person is covered 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.

B034.2852

All Options

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. The teeth lost, extracted or missing before a Covered Person becomes covered does not apply to a Covered Person's prosthetic device which replaces teeth: (1) that were extracted while he or she was covered by the prior Plan; and (2) for which extraction benefits were paid by the prior Plan.

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

Bridge abutments: See inlays, onlays and crowns under Group III Restorative Services.

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium
- 3/4 cast metal
- 3/4 porcelain

Bridge Pontics:

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- Titanium

Dentures: Allowance includes all adjustments and repairs done by the Dentist furnishing the denture in the first six 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.

B034.2865

All Options

Crown And Prosthodontic Restorative Services:

Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Also see Group III Restorative Services.

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 rebases 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 relines done more than 12 consecutive months after the insertion of the denture.

Denture adjustments: Denture adjustments done within six 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 six 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 one treatment, per arch, in any 12 consecutive month period.

B034.2883

All Options

Group III Covered Services do not include:

Replacing an existing Appliance or Dental Prosthesis with a like or unlike Appliance or Dental Prosthesis unless: (1) it is at least 5 years old and is no longer usable; or (2) damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable; or replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.

Any restoration, procedure, 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.

B034.2880

COORDINATION OF BENEFITS

This section applies when You also have group dental coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1. **"Allowable expense"** is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2. **"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:

   - Group dental benefits and group blanket or group remittance dental benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.

   - Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.

   - Dental benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3. **"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).

4. **"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:

   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
   - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

B034.2738

C. Effects of Coordination.
When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.
We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.
If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
We will coordinate benefits with plans, whether insured or self- insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer;

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

B034.2739

CONTINUATION RIGHTS

Coordination Between Continuation Sections

A Covered Person may be eligible to continue his or her group dental coverage under more than one Continuation Rights section at the same time. If he or she chooses to continue his or her group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

A Covered Person continuing coverage under more than one continuation section: (1) will not be entitled to duplicate benefits; and (2) will not be subject to the premium requirements of more than one section at the same time.

Uniformed Services Continuation Rights

If You enter or return from military service, You may be able to continue coverage under this Plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If Your group dental coverage under this Plan would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

Group dental coverage may be continued while You are in the military for up to 24 months starting on the date of absence from work. Continued coverage will end if You fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact Your Employer for details about this continuation provision, including required premium payments.

COBRA Continuation Rights

Employee and Dependent

Important Notice: The Federal Continuation Rights section may not apply to Your Employer's plan. You must contact Your Employer to find out if Your Employer is subject to the Federal continuation rights requirement. If Your Employer is subject to that requirement, the Federal Continuation Rights section applies to You.

Qualified Continuee: Under this section, the term "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 dental coverage as: (1) an active Employee; (2) the spouse of an active Employee; or (3) the dependent child of an active Employee. A child born to, or adopted by, an active Employee during a continuation provided by this section is also a qualified continuee. Any other person who would otherwise become eligible for group dental coverage during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Dental Coverage Ends: If Your group dental coverage would otherwise end due to Your termination of employment or reduction of work hours, You may elect to continue such coverage for up to 18 months, if You were not terminated due to gross misconduct.

The continuation: (1) may cover You or any other qualified continuee; and (2) 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 dental coverage would otherwise end due to Your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

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

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

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

B034.2733

All Options

If You Die While Covered: If You die while covered, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. The continuation can last for up to 36 months, subject to When Continuation Ends.

If Your Marriage Ends: If Your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental coverage would otherwise end may elect to continue such coverage. 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 dental coverage would otherwise end due to his or her loss of dependent eligibility as defined in this Plan, other than Your coverage ending, he or she may elect to continue such coverage. 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 dental coverage due to Your termination of employment or reduction of work hours, he or she 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 he or she 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 You become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after Your later termination of employment or reduction of work hours, will be the longer of: (1) 18 months (29 months if there is a disability extension) from Your termination of employment or reduction of work hours; or (2) 36 months from the date of Your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this section must notify Your Employer, in writing, of: (1) Your legal divorce or separation from Your spouse; (2) the loss of dependent eligibility, as defined in this Plan, of a covered dependent child; (3) 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; (4) 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 (5) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to Your Employer by a qualified continuee within 60 days of the latest of: (1) the date on which an event that would qualify a person for continuation under this section occurs; (2) the date on which the qualified continuee loses (or would lose) coverage under this Plan as a result of the event; or (3) the date the qualified continuee is informed of the responsibility to provide notice to Your Employer and this Plan's procedures for providing such notice.

Notice of a disability determination must be given to Your Employer by a qualified continuee within 60 days of the latest of: (1) the date of the Social Security Administration determination; (2) the date of the event that would qualify a person for continuation; (3) the date the qualified continuee loses or would lose coverage; or (4) the date the qualified continuee is informed of the responsibility to provide notice to Your Employer and this Plan's procedures for providing such notice. But, such notice must be given before the end of the first 18 months of continuation coverage.

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All Options

Your Employer's Responsibilities: A qualified continuee must be notified, in writing, of: (1) his or her right to continue this Plan's group dental coverage; (2) the premium he or she must pay to continue such coverage; and (3) the times and manner in which such payments must be made.

Your Employer must give notice of the following qualifying events to the Plan administrator within 30 days of the event: (1) Your death; or (2) termination of employment (other than for gross misconduct) or reduction in hours of employment; or (3) Medicare entitlement. Upon receipt of notice of a qualifying event from Your Employer or from a qualified continuee, the Plan administrator must notify a qualified continuee of the right to continue this Plan's group dental coverage no later than 14 days after receipt of notice.

If Your Employer is also the Plan administrator, in the case of a qualifying event for which the Employer must give notice to the Plan administrator, Your Employer must provide notice to a qualified continuee of the right to continue this Plan's group dental coverage within 44 days of the qualifying event.

If Your Employer determines that a person is not eligible for continued group dental coverage under this Plan, the Employer must notify him or her 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 dental coverage under this Plan is cancelled prior to the maximum continuation period, Your Employer must notify the qualified continuee as soon as practical following determination that the continued group dental coverage shall terminate.

Your Employer's Liability: Your Employer will be liable for the qualified continuee's continued group dental coverage to the same extent as, and in place of, us, if Your Employer fails: (1) to remit a qualified continuee's premium payment to us on time, causing the qualified continuee's continued group dental coverage to end; or (2) to notify the qualified continuee of his or her continuation rights as described above.

Election Of Continuation: To continue his or her group dental coverage, the qualified continuee must give Your Employer written notice that he or she elects to continue. This must be done by the later of: (1) 60 days from the date a qualified continuee receives notice of his or her continuation rights from Your Employer as described above; or (2) the date group dental coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

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

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

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

Grace In Payment Of Premium: A qualified continuee's premium payment is timely if, with respect to the first payment after he or she 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 in an amount that is not significantly less than the amount Your Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid, unless Your Employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to Your Employer.

When Continuation Ends: A qualified continuee's continued group dental coverage ends on the first of the following:

- With respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental coverage would otherwise end;
- With respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (1) the end of the 29 month period which starts on the date the group dental coverage 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 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;
- The date Your Employer ceases to provide any group dental coverage to any Employee;
- The end of the period for which the last premium payment is made;
- The date, after the date of election, a qualified continuee becomes covered under any other group dental coverage which does not contain any pre-existing condition exclusion or limitation affecting him or her;
- The date, after the date of election, the qualified continuee becomes entitled to Medicare; or
- With respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group dental coverage would otherwise end.

B034.2735

All Options

Your Right To Continue Dental Expense Coverage During A Family Leave Of Absence

Important Notice: This section may not apply to Your Employer's plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

If Your Coverage Would End: Your dental expense coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted to: (1) allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious injury or illness arising out of the fact that Your spouse, child, parent or next of kin who is a covered service member 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. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

When Continuation Ends: Continued coverage will end on the earliest of the following:

- The date You return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, if You care for a covered servicemember. This 26 week total leave period applies to all leaves granted to You under this section for all reasons.
- The end of a total leave period of 12 weeks in: (1) any later 12 month period, if You care for a covered servicemember; or (2) any 12 month period in any other case.
- The date on which Your coverage would have ended had You not been on leave.
- The end of the period for which 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: (1) 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 (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law 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 is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in outpatient status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.

- **Outpatient Status:**This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) 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 service member, 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: (1) office; (2) grade; (3) rank; or (4) rating.

B034.2730

All Options

Dependent Continuance On Your Death

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: (1) this group dental coverage remains in force; (2) the dependents remain eligible dependents; and (3) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, 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 the conditions shown in items (1), (2), and (3) 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 other continuation provision.

B034.4078

All Options

DENTAL EXPENSE COVERAGE SCHEDULE OF BENEFITS

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of the any applicable amendment requested by the Policyholder and approved by the Insurance Company, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B034.2926

All Options

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

Services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

DentalGuard **PPO** Benefit Year Cash Deductible for each Covered Person:

Group I Services	None
Group II and Group III Services	$25.00

Non-PPO Benefit Year Cash Deductible for each Covered Person:

Group I Services	None
Group II and Group III Services	$25.00

This Plan does not pay benefits for charges that it would otherwise cover to the extent that benefits for such charges are payable by Your Employer's medical plan.

B034.2965

All Options

Payment Rates PPO Payment Rate for services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

- DentalGuard **PPO** Payment Rate for:

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

- DentalGuard **Non-PPO** Payment Rate for:

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

B034.3135

All Options

Payment Limit PPO Benefit Year Payment Limit for Non-Orthodontic Services provided by a DentalGuard Preferred Preferred Provider and Non-Preferred Provider.

- Benefit Year Payment Limit $1,500.00

B034.3149

All Options

Changes in Coverage Amounts If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective until the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change.

B034.3161

CERTIFICATE RIDER - ROLLOVER OF BENEFIT YEAR PAYMENT LIMIT

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

B034.3238

All Options

Rollover of Benefit Year Payment Limit

A Covered Person may be eligible for a rollover of a portion of his or her unused Benefit Year payment limit 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, and that, in total, do not exceed the Rollover Threshold, he or she will be entitled to a Rollover, subject to all of the conditions described below.

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 will be entitled to a greater Rollover than if any of the benefits are for services of a Non-Preferred Provider.

Rollovers can accrue and are stored in the Covered Person's Rollover Account. If a Covered Person reaches his or her Benefit Year Payment Limit for Group I, Group II and Group III Services, we pay benefits up to the amount stored in the Covered Person's Rollover Account. The amount stored in the Rollover Account cannot be greater than the Rollover Account Maximum.

A Covered Person's Rollover Account will be eliminated, and the accrued Rollover 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, Rollover, and Rollover Account Maximum are:

Rollover Threshold $700.00

Rollover (if all benefits are for services provided by a Preferred Provider) $500.00

Rollover (if any benefits are for services provided by a Non-Preferred Provider) $350.00

Rollover Account Maximum $1,250.00

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 Benefit Year. In either case: (1) only claims incurred on or after January 1 of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Account until the Benefit Year that starts one year from the date the rollover provision first applies.

If charges incurred by a Covered Person for any dental services are not covered due to the application of any of this Plan's waiting periods or penalties for Late Entrants, this rollover provision will not apply with respect to the Covered Person until the end of such period.

If such waiting period or Late Entrant penalty 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. In that case: (1) only claims incurred on or after the start of the next Benefit Year will count toward the Rollover Threshold; and (2) Rollovers will not be applied to a Covered Person's Rollover Account until the Benefit Year that starts one year from the date the rollover provision first applies.

Definitions: As used in this rider, the terms listed below have the meanings shown below.

- **Rollover:** This term means the dollar amount which will be added to a Covered Person's Rollover Account when he or she receives benefits in a Benefit Year that do not exceed the Rollover Threshold.
- **Rollover Account:** This term means the amount of a Covered Person's accrued Rollover.
- **Rollover Account Maximum:** This term means the maximum amount of Rollover that a Covered Person can store in his or her Rollover Account.
- **Rollover Threshold:** This term means the maximum amount of benefits that a Covered Person can receive during a Benefit Year and still be entitled to receive a Rollover.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

B034.3243

GC-R-DENMAX-12-NY

CERTIFICATE RIDER - DOMESTIC PARTNERS

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

Domestic Partners

Your domestic partner may be treated as a spouse under this Plan, subject to the conditions below.

In order for a domestic partner to be treated as a spouse under this Plan, you and your domestic partner must have proof of the domestic partnership and financial interdependence in the form of:

A. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or

B. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

   1. The affidavit must be notarized and must contain the following:

      - The partners are both eighteen years of age or older and are mentally competent to consent to contract;
      - The partners are not blood related in a manner that would bar marriage under laws of the State of New York;
      - The partners have been living together on a continuous basis prior to the date of the application;
      - Neither individual has been registered as a member of a domestic partnership within the last six months; and

   2. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

3. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence.

   a. A joint bank account

   b. A joint credit account or charge card

   c. Joint obligation on a loan

   d. Status as an authorized signatory on the partner's bank account, credit card or charge card

   e. Joint ownership of holdings or investments

   f. Joint ownership of a residence

   g. Joint ownership of real estate other than residence

   h. Listing of both partners as tenants on the lease of the shared residence

   i. Shared rental payments of residence (need not be shared 50/50)

   j. Listing both partners as tenants on a lease, or shared rental payments, for property other than residence

   k. A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)

   l. Shared household budget for purposes of receiving government benefits

   m. Status of one as representative payee for the other's government benefits

   n. Joint ownership of major items of personal property (e.g., appliances, furniture)

   o. Joint ownership of a motor vehicle

   p. Joint responsibility for child care (e.g., school documents, guardianship)

   q. Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)

   r. Execution of wills naming each other as executor and/or Beneficiary

   s. Designation as beneficiary under the other's life insurance policy

   t. Designation as beneficiary under the other's retirement benefits account

   u. Mutual grant of durable power of attorney

   v. Mutual grant of authority to make health care decisions (e.g., health care power of attorney)

w. Affidavit by creditor or other individual able to testify to partner's financial interdependence

x. Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

GC-R-DENDP-12-NY B034.3252

CERTIFICATE RIDER - DENTAL OPTIONS PROGRAM

Effective on the latter 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 this Plan by the addition of the following:

Dental Options Program

The Alternate Treatment provision is changed to read as follow when titanium or high noble metal (gold) is used in a Dental prosthesis.

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 missing 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 titanium or high noble metal (gold) used in a Dental prosthesis, the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

GC-R-DENOPT-12-NY B034.3280

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

All Options

The Guardian's Responsibilities

B800.0048

All Options

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

B800.0053

All Options

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

B800.0049

Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

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

Definitions

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

"Group Health Benefits" means any dental or vision care coverages which are a part of this plan.

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B055.0065

Termination of This Group Plan

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

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

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

B800.0007

All Options

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees)

Group Policy No.: G-00529922

Issued to: MARCHESE FORD OF MECHANICVILLE

Amendment Effective: The later of: 1) January 1, 2015 or 2) the Planholder's first renewal date thereafter; or 3) the effective date of any amendment which replaces or adds such Certificate langauge providing Group Pediatric Dental Expense Coverage.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Michael Estep, Vice President

CGP-A-1 B950.1782

This is Your
PREFERRED PROVIDER ORGANIZATION DENTAL INSURANCE CERTIFICATE OF COVERAGE

Issued by The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

Group Policyholder: MARCHESE FORD OF MECHANICVILLE
Group Policy Number: 00529922

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Policy between The Guardian Life Insurance Company of America (hereinafter referred to as "We", "Us", or "Our") and the Group listed in the Group Policy. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

Issued To:	
Certificate Number:	Effective Date:

This Certificate offers You the option to receive Covered Services on two benefit levels.

In-Network Benefits In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our DentalGuard Preferred network. You should always consider receiving dental care services first through the in-network benefits portion of this Certificate. In-network care covered under this Certificate must be provided, arranged or authorized in advance by Your Primary Care Dentist and, when required, approved by Us. In order to receive in-network benefits, You must contact Your Primary Care Dentist before You obtain the services except for Emergency Dental Care described in the Pediatric Dental Care section of this Certificate.

Out-of-Network Benefits. The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. See the Schedule of Benefits in Section XIV of the Certificate for more information.

This Certificate is a New York State of Health, The Official Health Plan Marketplace, certified stand-alone dental plan offered outside the New York State of Health.

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN

THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

The Insurance evidenced by this Certificate provides DENTAL insurance ONLY.

The Guardian Life Insurance Company of America

Michael Estep, Vice President

B950.2449

GC-EHB-20-NY

TABLE OF CONTENTS

SECTION I. Definitions

Defined terms will appear capitalized throughout the Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by The Guardian Life Insurance Company of America, including the Schedule of Benefits and any attached riders. The Certificate explains the benefits available to You under the Group Policy.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance is applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Children.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Pediatric Dental Care section of this Certificate for details.

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

General Dentist: A dentist licensed under Title 8 of the New York State Education Law (or other comparable state law, if applicable) who is not a Secialist.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a Policyholder.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In- Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover. The In-Network Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

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All Options

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber and covered Dependents for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost- sharing based on income; choose a plan; and enroll in coverage. The NYSOH helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus and the Essential Plan.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Coinsurance or Copayments are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of dental care services We do not Cover. The Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

Participating Provider: A Provider who has a contract with Us to provide services to You. A list of Participating Providers and their locations is available on Our website at www.guardianlife.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. Medical Doctor or D.O. Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan or device that the Covered Service, procedure, treatment plan, device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Premium: The amount that must be paid for Your dental insurance coverage.

Premium Tax Credit: Financial help that lowers Your taxes to help You and Your family pay for private dental insurance. You can get this help if You get health insurance through the NYSOH and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly Premium.

Primary Care Dentist ("PCD"): A participating dentist who directly provides or coordinates a range of dental care services for You.

Provider: An appropriately licensed, registered or certified dentist; dental hygienist; or dental assistant under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Certificate.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member.

Responsible Adult: The person who enters into this Certificate with Us on behalf of his or her Child or Children.

Schedule of Benefits: The section of this Certificate that describes the Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by The State of New York in which We provide coverage. Our Service Area consists of all counties within New York State.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Certificate is issued. In the case of a Certificate that provides coverage for Pediatric Dental Care only, the Subscriber refers to the Responsible Adult if the member is under 18 years of age.

UCR (Usual, Customary and Reasonable): The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar dental service.

Us, We, Our: The Guardian Life Insurance Company of America and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

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SECTION II. How Your Coverage Works

A. Your Coverage under this Certificate.

Your Employer (referred to as the "Group") has purchased a Group Dental Insurance Policy from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and/or their Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for In-Network Coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request.
- Call Member Services at 1-800-541-7846.
- Visit our website at www.guardianlife.com.

D. The Role of Primary Care Dentists.

This Certificate does not have a gatekeeper, usually known as a Primary Care Dentist (PCD). You do not need a Referral from a PCD before receiving Specialist care from a Participating Provider.

E. Out-of-Network Services.

We Cover the services of Non-Participating Providers outside Our Service Area. However, some services are only Covered when you go to a Participating Provider. See the Schedule of Benefits of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

F. Services Subject To Preauthorization.

Our Preauthorization is not required before You receive certain Covered Services.

G. Pre-Determination/Pre-Treatment Estimates.

We allow You to request and obtain an estimate of coverage. You or Your Provider may contact Us and request a pre-determination of benefits, also known as a pre-treatment estimate. If We determine that an alternative procedure or treatment is more appropriate than the requested service, You may appeal Our decision through an internal Appeal or external appeal. See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal.

H. Medical Management.

The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

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All Options

I. Medically Necessary.

We Cover benefits described in this Certificate as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups Physicians;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally- recognized health specialty involved.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal appeal and external appeal of Our determination that a service is not Medically Necessary.

J. Important Telephone Numbers and Addresses.

CLAIMS
P.O. Box 981572
El Paso, TX 79998-15572
(Submit claim forms to this address.)

CRU@glic.com
(Submit electronic claim forms to this address.)

COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
1-800-541-7846

MEMBER SERVICES
1-800-541-7846
(Member Services Representatives are available Monday - Friday, 8:00 am - 5:00 pm.)

OUR WEBSITE
www.guardianlife.com

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SECTION III. Access To Care and Transitional Care

A. When Your Provider Leaves the Network

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates.

In order for You to continue to receive Covered services for up to ninety (90) days, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

B. New Members In a Course of Treatment

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease.

In order for You to continue to receive Covered services for up to sixty (60) days the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary dental information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will only be responsible for any applicable In-Network Cost-Sharing.

B950.2450

SECTION IV. Cost-Sharing Expenses and Allowed Amount

A. Deductible. Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply towards Your In-Network Deductible. Cost-Sharing for in-netowrk services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.**

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments. There are no Copayments for Covered Services under this Certificate.

C. Coinsurance. Except where stated otherwise, after You have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit. When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles, and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate for the pediatric dental essential health benefit, We will provide coverage for 100% of the Allowed Amount for Covered In-Network Services for the remainder of that Plan Year for the pediatric dental essential health benefit. If you have other than individual coverage, the individual Out-Of-Pocket Limit applies to each Member under age 19 covered under this Certificate. Once a Member under age 19 meets the In-Network Out-of-Pocket Limit for one (1) Member under age 19, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person for the pediatric dental essential health benefit. If this Certificate covers more than One Member under age 19, when two (2) or more Members under age 19 covered under this Certificate have collectively met the In-Network Out-of-Pocket Limit for two (2) or more Members under age 19 in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the pediatric dental essential health benefit for the rest of that Plan Year.

Cost-Sharing for out-of-network services, except for out-of-network services approved by Us as an in-network exception, does not apply towards Your In-Network Out-of-Pocket Limit.

The In-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Out-of-Network Out-of-Pocket Limit for Pediatric Dental Essential Health Benefit. This Certificate does not have an Out-of-Network Out-of-Pocket Limit on the pediatric dental essential health benefit.

F. Out-of-Network Out-of-Pocket Limit. This Certificate does not have an Out-of-Network Out-of-Pocket Limit.

B950.2416

All Options

G. Your Additional Payments for Out-of-Network Benefits. When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. As an example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

H. Allowed Amount. Allowed Amount means the maximum amount We will pay for the services or supplies covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider or the participating provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. **For Providers.**
   For Providers, the Allowed amount will be an amount based on Our Participating Provider fee schedule or rate.

Our Allowed Amount is not based on UCR and the Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the telephone number on Your ID card or visit our website at www.guardianlife.com for information on Your financial responsibility when You receive services from a Non-Participating Provider.

B950.2417

SECTION V. Who Is Covered

A. Who is Covered Under this Certificate.

This Certificate is issued to cover Members (known as You) who are under 19 years of age. Coverage lasts until the end of the month in which You turn 19 years of age.

B. Children Covered Under This Certificate.

"Children" covered under this Certificate include the Subscriber's natural Children, legally adopted Children, step Children, and Children for whom the Subscriber is the proposed adoptive parent without regard to financial dependence, residency with the Subscriber, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as natural Child during any waiting period prior to the finalization of the Child's adoption.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or Covered Member and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

C. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If the Subscriber elects coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date Subscriber become eligible, or on the date determined by the Group.

2. If the Subscriber does not elect coverage upon Becoming eligible or within 30 days of becoming eligible for other than a special enrollment period, the Subscriber must wait until the Group's next open enrollment period to enroll, except as provided below.

3. If the Subscriber has a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for the Subscriber's newborn starts at the moment of birth; otherwise coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if the Subscriber takes physical custody of the infant as soon as the infant is released from the Hospital after birth and the Subscriber files a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant s birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. In order for coverage to start at the moment of birth, the Subscriber must notify Us and pay any additional Premium within the 30 day period. Otherwise, coverage begins on the date We receive notice, provided that You pay any additional Premium when due.

D. Special Enrollment Periods.

You can also enroll for coverage within 30 days of the loss of coverage in another group dental plan if coverage was terminated because You are no longer eligible for coverage under the other group dental plan due to:

1. Termination of employment;
2. Termination of the other group dental plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions towards the group dental plan were Terminated for You; or
7. A Child no longer qualifies for coverage as a Child under the other group dental plan.

You can also enroll 30 days from exhaustion of Your COBRA coverage.

We must receive notice and Premium payment within 30 days of one of these events. The effective date of Your coverage will depend on when We receive Your application. If Your application is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month. If Your application is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of birth, adoption or placement for adoption.

In addition, You can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You lose eligibility for Medicaid or a state child dental plan.
2. You become eligible for Medicaid or a state child dental plan.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

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SECTION VI. Pediatric Dental Care

Please refer to the Schedule of Benefits of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits

We Cover the following dental care services for Members through the end of the month in which the Members turn 19 years of age:

A. Emergency Dental Care: We Cover Emergency Dental Care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.

B. Preventive Dental Care: We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36 month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics: We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics: We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Certificate.

F. Prosthodontics: We Cover prosthodontic services as follows:

- Removable complete or partial dentures, for Members 15 years of age and above, including six (6) months follow-up care;

- Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.

We do not cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Certificate.

H. Orthodontics: We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry(craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

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SECTION VII. Exclusions and Limitations

No Coverage is available under this Certificate for the following:

A. Cosmetic Services.

We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect, except for pediatric orthodontics as described in the Pediatric Dental Care section of this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

B. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

C. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

D. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

E. Medical Services.

We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

F. Medically Necessary.

In general, We will not Cover any dental service, procedure, treatment, or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, or device for which Coverage has been denied, to the extent that such service, procedure, treatment, test, or device is otherwise Covered under the terms of this Certificate.

G. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

H. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

I. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

J. Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

K. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

L. Services With No Charge.

We do not Cover services for which no charge is normally made.

M. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION VIII. Claims Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on your ID card or visiting Our website at www.guardianlife.com. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by visiting Our website www.guardianlife.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see Utilization Review and External Appeal sections of this Certificate.

F. Pre-service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received.

   If We have all the information necessary to make a determination regarding a pre-service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

2. **Urgent Pre-service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three calendar days of the decision.

G. Post-service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

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SECTION IX. Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at the telephone number on Your ID card, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:

> By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)

> In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances: (A claim for a service or a treatment that has already been provided.)

> In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)

> In writing, within 30 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal [by phone at the number on Your ID card or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Services Grievances: (A request for a service or treatment that has not yet been provided.)

15 calendar days of receipt of Your Appeal.

Post-Service Grievances: (A claim for a service or treatment that has already been provided.)

30 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)

30 calendar days of receipt of Your Appeal.

E. Assistance.

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
www.dfs.ny.gov

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY. 10017
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

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SECTION X. Utilization Review

A. Utilization Review

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the telephone number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us by calling the telephone number on Your ID card or visit Our website at www.guardianlife.com.

B. Preauthorization Reviews

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45 day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier one (1) business day of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

D. Retrospective Reviews

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer Reviewer who made the adverse determination or a designated clinical peer review if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

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All Options

G. Utilization Review Internal Appeals

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

H. Standard Appeal

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

J. Appeal Assistance.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY. 10017
Or call toll free: 1-888-614-5400
Or e-mail cha@cssny.org
www.communityhealthadvocates.org

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SECTION XI. External Appeals

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care, or effectiveness of a Covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases). You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Contract and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization Review claim processing Requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right To Appeal A Determination That A Service is Not Medically Necessary

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment, (including clinical trials and treatments for rare diseases). You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that: (1) Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**

2. There does not exist a more beneficial standard service or procedure covered by Us; **or**

3. There exists a clinical trial or rare disease treatment(as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation - Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or

3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal A Determination that a Service is Out of Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Authorization Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have Three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external 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 Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within Two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment We will provide coverage subject to the other terms and conditions of this Certificate. 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 You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

G. Your Responsibilities

It is Your RESPONSIBILITY to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

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Section XII. Coordination of Benefits

This section applies when You also have group dental coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments.

A. Definitions.

1.**"Allowable expense"** is the necessary, reasonable, and customary item of expense for dental care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.

2.**"Plan"** is other group dental coverage with which We will coordinate benefits. The term "plan" includes:

- Group dental benefits and group blanket or group remittance dental benefits coverage, whether insured, self-insured, or self- funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
- Dental benefits coverage, in group and individual automobile "no-fault" and traditional liability "fault" type contracts.
- Dental benefits coverage of a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private benefits coverage.

3.**"Primary plan"** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: (1) the plan has no order of benefits rules or its rules differ from those required by regulation; or (2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan(for example, two plans which have no order of benefit determination rules).

4.**"Secondary plan"** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.

2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.

3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year shall be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.

4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's dental care expenses:

   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
   - If a court decree between the parents says which parent is responsible for the child's dental care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.

5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.

6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

B950.1715

All Options

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.

We will coordinate benefits with plans, whether insured or self- insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.

2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer;

3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

B950.1716

SECTION XIII. Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply.

1. The Group, and/or Subscriber, has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.

2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.

3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Children, until the end of the month in which the Child turns 19 years of age.

5. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

6. If a Subscriber 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 the Subscriber. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

7. The date that the Group Policy is terminated. If We decide to stop offering a particular class of group policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days prior written notice.

8. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

9. The Group has failed to comply with a material plan provision relating to group participation rules. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

10. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.

11. The date there is no longer any enrollee who lives, resides, or works in Our Service Area.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage under COBRA or USERRA.

B950.2424

SECTION XIV. Extension of Benefits

Upon termination of insurance whether due to termination of eligibility, or termination of the policy, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that started before the covered person's coverage ended.

SECTION XV. Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA.

Qualifying Events.

Pursuant to federal COBRA, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g. a reduction in the number of hours of employment) You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.

2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber's employment;
   - Reduction in the hours worked by the Subscriber or other change in the employee's class;
   - Divorce or legal separation of the Subscriber;
   - Death of the Subscriber; or
   - The Subscriber becoming entitled to Medicare.

3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
   - Voluntary or involuntary termination of the Subscriber employment;
   - Reduction in the hours worked by the Subscriber or other change in the employee's class;
   - Loss of covered Child status under the plan rules;
   - Death of the Subscriber; or
   - The Subscriber becoming entitled to Medicare.

If You want to continue coverage You must request continuation from The Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 18 months after the Subscriber's coverage would have terminated because of termination of employment; provided that the Subscriber or their dependents may continue for a total of 29 months is the Member is determined to be disabled under the United States Social Security Act.
2. If You are a covered Spouse or Child the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Policy terminates. However, if the Group Policy is replaced with similar coverage, You have the right to become covered under the new Group Policy for the balance of the period remaining for Your continued coverage.

Continuation Rights During Active Duty

Under the Uniformed Services Employment and Reemployment Rights Act ('USERRA'), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end due to service in the uniformed services or upon becoming eligible for medical and dental care under federal health insurance by reason of their service. Call or write Your Group to find out if You are entitled to temporary continuation of coverage under USERRA.

The Group may charge up to 102% of the Group Premium for continued coverage. This does not apply if You or Your dependents serve less than 31 days.

Continued coverage under this section will terminate at the earliest of the following:

1. The 24-month period beginning on the date on which the absence begins; or
2. The day after the date on which You or Your Dependent fail to apply for or return to a position of employment.

An exclusion or waiting period may not be imposed in connection with the reinstatement of coverage upon reemployment unless an exclusion or waiting period would have been imposed under the health plan had coverage not been terminated.

1. This shall not apply to the coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services.
2. If You or Your Dependent's coverage under a health plan is terminated by reason of the person having become eligible for federal health insurance for former members of the uniformed services and their dependents, but subsequently do not commence a period of active duty under the order to active duty that established such eligibility because the order is canceled before such active duty commences, any exclusion or waiting period in connection with the reinstatement of coverage shall apply to the continued employment in the same manner as if You or Your Dependents had become reemployed upon such termination of eligibility.

B950.2425

SECTION XVI. General Provisions

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any dental benefits program.

2. **Assignment.** You cannot assign any benefits under this Certificate to any person, corporation, or other organization. Any assignment of benefits by You will be void and unenforceable. Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Certificate

3. **Changes in This Certificate.** We may unilaterally change this Certificate upon renewal, if We give the Group Policyholder 30 days' prior written notice.

4. **Choice of Law.** This Certificate shall be governed by the laws of the State of New York.

5. **Clerical Error.** Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Conformity with Law.** Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will amended to conform with the minimum requirements of such law.

7. **Continuation of Benefit Limitations.** Some of the benefits in this Certificate may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. **Entire Agreement.** This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

9. **Furnishing Information and Audit.** The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your dentist; or to make decisions regarding the medical necessity of Your dental care. The Group Policyholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group's New York office.

10. **Identification Cards.** Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.

11. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

12. **Material Accessibility.** We will give the Group, and the Group will give You, identification cards, Certificates, riders, and other necessary materials.

13. **More Information about Your Dental Plan.** You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.

    - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
    - The information that We provide the State regarding Our consumer complaints.
    - A copy of Our procedures for maintaining confidentiality of Member information.
    - A written description of Our quality assurance program.
    - A copy of Our medical policy regarding an experimental or investigational drug, medical or treatment in clinical trials.
    - A copy of Our clinical review criteria, (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
    - Written application procedures and minimum qualification requirements for Providers.

14. **Notice.** Any notice that We give to You under This Certificate will be mailed to Your address as it appears in Our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to the address shown on Your ID card.

15. **Premium Refund.** We will give any refund of Premiums, if due, to the Group.

16. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

17. **Renewal Date.** The renewal date for the Certificate is the anniversary of the effective date of the Group Policy each Year. This Certificate will automatically renew each year on the renewal date unless otherwise terminated by Us as permitted by this Certificate, or by the Group upon 30 days prior written notice to Us.

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All Options

18. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

19. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

20. **Severability.** The unenforceability or invalidity of any provision of this Certificate; shall not affect the validity and enforceability of the remainder of this Certificate.

21. **Third Party Beneficiaries.** No third party beneficiaries are intended to be created by this Certificate and nothing in the Certificate shall confer upon any person or entity other than You or Us and right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

22. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

23. **Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Please contact us at the telephone number on Your ID card to access these services.

24. **Venue for Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.

25. **Waiver.** The waiver by any party of any breach of any provision of the Certificate; will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

26. **Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Operating Officer (COO); Chief Executive Officer (CEO); President or a person designated by the COO, CEO or President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the COO, CEO or President or person designated by the COO, CEO or President.

27. **Who Receives Payment under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

28. **Workers' Compensation Not Affected.** The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

29. **Your Dental Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

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SECTION XVII. Schedule Of Benefits / END OF CONTRACT

PREFERRED PROVIDER ORGANIZATION DENTAL INSURANCE

MARCHESE FORD OF MECHANICVILLE

The Guardian Life Insurance Company of America

A Mutual Company Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

COST SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT			
Deductible			
• One (1) Member under age 19	$150.00	$150.00	
• Two (2) or More Members under age 19	$300.00	$300.00	
Out-of-Pocket Limit			
• One (1) Member under age 19	$350.00	None	
• Two (2) or More Members under age 19	$700.00	None	
Annual and Lifetime Limits	None	None	

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			
• Emergency Dental	30% Coinsurance not subject to Deductible	30% Coinsurance After Deductible	
• Preventive Dental Care	30% Coinsurance not subject to Deductible	30% Coinsurance After Deductible	One Dental Exam & Cleaning Per 6-Month Period
• Routine Dental Care	50% Coinsurance After Deductible	50% Coinsurance After Deductible	Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at 6 month intervals
• Endodontics	50% Coinsurance After Deductible	50% Coinsurance After Deductible	
• Periodontics	50% Coinsurance After Deductible	50% Coinsurance After Deductible	
• Prosthodontics	50% Coinsurance After Deductible	50% Coinsurance After Deductible	

• Oral Surgery	50% Coinsurance After Deductible	50% Coinsurance After Deductible	
• Orthodontics	50% Coinsurance After Deductible	50% Coinsurance After Deductible	

Section XVIII. CERTIFICATE RIDER Domestic Partner Rider

Effective on the effective date of the Subscriber's Certificate, this rider amends this Plan by the addition of the following:

A. Domestic partner Coverage.

This Rider amends Your Certificate to provide coverage for domestic partners. This rider covers domestic partners of Subscribers as Spouses. If you selected family coverage, Children covered under the Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last 12 months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.

    a. The affidavit must be notarized and must contain the following:

    - The partners are both eighteen years of age or older and are mentally competent to consent to contract;
    - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
    - The partners have been living together on a continuous basis prior to the date of the application; and

b. Neither individual has been registered as a member of another domestic partnership within the last 12 months; and

c. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and

d. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence

- A joint bank account;
- A joint credit card or charge card;
- Joint obligation on a loan;
- Status as an authorized signatory on the partner's bank account, credit card or charge card;
- Joint ownership of holdings or investments;
- Joint ownership of residence;
- Joint ownership of real estate other than residence;
- Listing of both partners as tenants on the lease of the shared residence;
- Shared rental payments of residence (need not be shared 50/50);
- Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;

- A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
- Shared household budget for purposes of receiving government benefits;
- Status of one as representative payee for the other s government benefits;
- Joint ownership of major items of personal property (e.g., appliances, furniture);
- Joint ownership of a motor vehicle;
- Joint responsibility for child care (e.g., school documents, guardianship);
- Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
- Execution of wills naming each other as executor and/or beneficiary;
- Designation as beneficiary under the other s life insurance policy;
- Designation as beneficiary under the other s retirement benefits account;
- Mutual grant of durable power of attorney;
- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partners financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

B. Controlling Certificate.

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CG-A-DEN-DP-20-NY B950.2433

IMPORTANT NOTICE REGARDING LANGUAGE ASSISTANCE & DISCRIMINATION
AVISO IMPORTANTE SOBRE LA ASISTENCIA DE IDIOMA Y DISCRIMINACIÓN

English	If you or the person you are helping has questions about your insurance benefits, claims, or coverage, you have the right to get help and information in your language at no cost. To talk to an interpreter: if you have insurance from your employer, call the telephone number on your identification card; for all other members, please call 844-561-5600. The Guardian and its subsidiaries* comply with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Spanish **Español**	Si usted o la persona que está ayudando tiene preguntas acerca de su seguro, las reclamaciones o cobertura, usted tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete: si tiene seguro de su empleador, llame al número de teléfono que aparece en su tarjeta de identificación; para todos los demás miembros, por favor llame al 844-561-5600. The Guardian y sus subsidiarias * cumplir con las leyes federales aplicables de derechos civiles y no discrimina por motivos de raza, color, origen nacional, edad, discapacidad, o sexo.
Chinese **中文**	**如果你或你正在帮助的人**拥有约你的保险利益，索赔或覆盖的问题，你有没有成本，以获取帮助和信息在你的语言的权利。要交谈的解释：如果您从您的雇主有保险，打电话给你的身份证上的电话号码;所有其他成员，请致电 844-561-5600。 卫报及其子公司*遵守适用的联邦民权法和种族，肤色，国籍，年龄，残疾，或性的基础上不歧视。
Vietnamese **Tiếng Việt**	Nếu bạn hoặc người bạn đang giúp đỡ có câu hỏi về quyền lợi bảo hiểm, yêu cầu của bạn, hoặc bảo hiểm, bạn có quyền được trợ giúp và thông tin trong ngôn ngữ của bạn miễn phí. Để nói chuyện với một thông dịch viên: nếu bạn có bảo hiểm từ công ty của bạn, hãy gọi số điện thoại trên thẻ nhận dạng của bạn; cho tất cả các thành viên khác, xin vui lòng gọi 844-561-5600. The Guardian và các công ty con của nó * tuân thủ pháp luật quyền dân sự liên bang áp dụng và không phân biệt đối xử trên cơ sở chủng tộc, màu da, nguồn gốc quốc gia, tuổi tác, khuyết tật, hoặc quan hệ tình dục.
Korean **한국어**	당신이나 당신이 도움이되고 사람이 당신의 보험 혜택, 청구, 또는 범위에 대한 질문이있는 경우, 당신은 무료로 귀하의 언어로 도움과 정보를 얻을 수있는 권리가 있습니다. 통역 얘기하려면, 당신은 당신의 고용주로부터 보험이있는 경우, 귀하의 ID 카드에 전화 번호로 전화; 다른 모든 구성원에 대해, 844-561-5600로 전화 해주십시오. 가디언과 그 자회사는 해당 연방 민권법을 준수하고 인종, 피부색, 출신 국가, 연령, 장애, 또는 성별에 근거하여 차별하지 않습니다 *.
Tagalog **Tagalog**	Kung ikaw o ang taong ikaw ay pagtulong ay may mga katanungan tungkol sa inyong mga benepisyo sa insurance, claims, o coverage, ikaw ay may karapatan upang makakuha ng tulong at impormasyon sa iyong wika nang walang gastos. Upang makipag-usap sa isang interpreter: kung mayroon kang insurance mula sa iyong tagapag-empleyo, tawagan ang numero ng telepono sa iyong identification card; para sa lahat ng iba pang mga miyembro, mangyaring tumawag sa 844-561-5600. The Guardian at ang mga subsidiaries * sumusunod sa naaangkop na mga Pederal na batas sa mga karapatang sibil at hindi maaaring makita ang kaibhan sa batayan ng lahi, kulay, bansang pinagmulan, edad, kapansanan, o sex.
Russian **Русский**	Если вы или человек, которому вы помогаете есть вопросы по поводу вашего страховых выплат, претензий, или покрытия, вы имеете право получить помощь и информацию на вашем языке без каких-либо затрат. Для того, чтобы поговорить с переводчиком: если у вас есть страхование от Вашего работодателя, позвоните по номеру телефона на вашей идентификационной карточки; для всех остальных членов, просьба звонить по телефону 844-561-5600. The Guardian и его дочерние компании * соответствии с действующими федеральными законами о гражданских правах и не допускать дискриминации по признаку расы, цвета кожи, национального происхождения, возраста, инвалидности или пола.
Arabic العربية	إذا كنت أنت أو الشخص الذي يساعد ديه أسئلة حول فوائد التأمين والمطالبات، أو تغطية، لديك الحق في الحصول على المساعدة والمعلومات في لغتك دون أي تكلفة. التحدث الى مترجم: إذا كان لديك التأمين من صاحب العمل الخاص بك، الاتصال على رقم الهاتف على بطاقة الهوية الخاصة بك. لجميع الأعضاء، يرجى الاتصال 844-561-5600. الجارديان والشركات التابعة لها * الالتزام بالقوانين الاتحادية المطبقة الحقوق المدنية ولا تميز على أساس العرق أو اللون أو الأصل القومي أو السن أو الإعاقة، أو الجنس..
French Creole-Haitian Creole **Kreyòl Ayisyen**	Si ou menm oswa moun nan w ap ede gen kesyon sou benefis asirans ou, reklamasyon, oswa pwoteksyon, ou gen dwa pou jwenn èd ak enfòmasyon nan lang ou a pa koute. Pou pale ak yon entèprèt: si ou gen asirans nan men anplwayè ou, rele nimewo telefòn sou kat idantifikasyon ou; pou tout lòt manm, tanpri rele 844-561-5600. The Guardian ak filiales li yo * konfòme yo avèk lwa sou dwa sivil Federal aplikab yo, epi pa fè diskriminasyon sou baz ras, koulè, orijin nasyonal, laj, andikap, oswa fè sèks.
Polish **Polskie**	Jeśli Ty lub osoba, do której pomoc ma pytania dotyczące świadczeń z ubezpieczenia, roszczenia lub pokrycia, masz prawo do uzyskania pomocy i informacji w swoim języku, bez żadnych kosztów. Aby rozmawiać z tłumacza: jeśli masz ubezpieczenie od pracodawcy, należy zadzwonić pod numer telefonu na karcie identyfikacyjnej; dla wszystkich pozostałych członków, zadzwoń 844-561-5600. The Guardian i jej spółek zależnych * przestrzegania obowiązujących przepisów federalnych praw obywatelskich i nie dyskryminacji ze względu na rasę, kolor skóry, pochodzenie narodowe, wiek, niepełnosprawność, czy płeć.

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French **Français**	Si vous ou la personne que vous aidez a des questions sur vos prestations d'assurance, les prétentions ou la couverture, vous avez le droit d'obtenir de l'aide et de l'information dans votre langue, sans frais. Pour parler à un interprète: si vous avez l'assurance de votre employeur, appelez le numéro de téléphone sur votre carte d'identité; pour tous les autres membres, s'il vous plaît appelez 844-561-5600. The Guardian et ses filiales * sont conformes aux lois fédérales relatives aux droits civils applicables et ne fait pas de discrimination sur la base de la race, la couleur, l'origine nationale, l'âge, le handicap ou le sexe.
Italian **Italieno**	Se voi o la persona che state aiutando ha domande circa la vostra prestazioni assicurative, reclami, o la copertura, si ha il diritto di richiedere assistenza e informazioni nella propria lingua, senza alcun costo. Per parlare con un interprete: se avete l'assicurazione dal datore di lavoro, chiamare il numero di telefono sulla carta d'identità; per tutti gli altri membri, si prega di chiamare 844-561-5600. The Guardian e le sue controllate * conformi alle leggi federali vigenti diritti civili e non discrimina sulla base di razza, colore, nazionalità, età, disabilità, o di sesso.
Persian-Farsi **ی‌فارس-ی‌فارس**	اگر شما یا شخصی که شما در حال کمک به سوالات در مورد مزایای بیمه خود را، ادعا می کند، و یا پوشش، شما حق دریافت کمک و اطلاعات به زبان خود را بدون هیچ هزینه داشته باشد. برای صحبت با یک مترجم: اگر بیمه از کارفرمای خود، تماس با شماره تلفن بر روی کارت شناسایی خود را. برای همه اعضای دیگر، لطفا 844-561-5600 تماس بگیرید.. گاردین و شرکتهای تابعه آن * * * * مطابق با قوانین فدرال حقوق مدنی قابل اجرا می کند و بر اساس نژاد، رنگ پوست، ملیت، سن، معلولیت و یا رابطه جنسی قائل نمی شود.
Armenian **Հայերեն**	Եթե դուք կամ այն անձը, դուք օգնում ունի հարցեր ձեր ապահովագրական հատուցումներից, պահանջների, կամ լուսաբանման, դուք իրավունք ունեք ստանալու օգնություն եւ տեղեկատվություն Ձեր լեզվով ոչ մի գնով: Խոսել է թարգմանչի: Եթե ունեք ապահովագրություն Ձեր գործատուի, զանգահարեք հեռախոսահամարը Ձեր նույնականացման քարտ. բոլոր մյուս անդամների համար, խնդրում ենք զանգահարել 844-561-5600. The Guardian եւ իր դուստր ձեռնարկություններն * համապատասխանեն կիրառելի դաշնային քաղաքացիական իրավունքների օրենքների եւ չի խտրականություն հիման վրա ռասայի, մաշկի գույնի, ազգային ծագման, տարիքի, հաշմանդամության, կամ սեռից:
German **Deutsche**	Wenn Sie oder die Person, die Sie helfen, Fragen zu Ihrem Versicherungsleistungen , Ansprüche oder Abdeckung, haben Sie das Recht auf kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um auf einen Dolmetscher sprechen: Wenn Sie eine Versicherung von Ihrem Arbeitgeber haben, rufen Sie die Telefonnummer auf der Ausweiskarte ; für alle anderen Mitglieder, rufen Sie bitte 844-561-5600. The Guardian und ihre Tochtergesellschaften * mit den geltenden Bundes Bürgerrechte Gesetze einhalten und nicht zu diskriminieren auf der Grundlage von Rasse, Hautfarbe , nationaler Herkunft, Alter, Behinderung oder Geschlecht.
Portuguese **Português**	Se você ou a pessoa que você está ajudando tem dúvidas sobre seus benefícios de seguro, reivindicações, ou cobertura, você tem o direito de obter ajuda e informações na sua língua, sem nenhum custo. Para falar com um intérprete: se você tem seguro de seu empregador, ligue para o número de telefone no seu cartão de identificação; para todos os outros membros, ligue para 844-561-5600. Este aviso tem informações importantes sobre a sua aplicação ou sua cobertura de seguro. Olhe para as datas-chave neste The Guardian e suas subsidiárias * cumprir com as leis federais aplicáveis direitos civis e não discriminar com base em raça, cor, nacionalidade, idade, deficiência ou sexo.

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