YOUR
GROUP INSURANCE
PLAN

UTICA UNIVERSITY

CLASS 0001

DENTAL

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

Employer-Funded Benefits Not Insured By Guardian

This Certificate explains the coverage your Employer offers. It explains the benefits available, as well as the requirements and limits of this coverage.

This is not insurance provided by Guardian. Instead, your Employer has engaged Guardian only to provide administrative services, such as processing claims. Your Employer's funds will be used to pay these claims. Your Employer is solely responsible and liable for the benefits available under this Plan.

B115.0130

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

EVIDENCE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

GROUP DENTAL EXPENSE COVERAGE

This evidence of coverage verifies that the employee to whom this booklet is issued is covered by the Plan Sponsor for the benefits described herein, provided the eligibility requirements are met.

The Employee and/or his 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 coverage evidenced by this booklet provides DENTAL benefits only.

Planholder: UTICA UNIVERSITY

Group Plan Number: 00579411

Michael Prestileo, Senior Vice President

B034.3534

TABLE OF CONTENTS

TABLE OF CONTENTS (CONT.)

IMPORTANT NOTICE

The Dental benefits are directly funded through and provided by your employer, and are not insured by Guardian. Guardian supplies administrative services, such as: claims services and preparation of employee benefit booklets.

Your employer, has the sole responsibility and liability for payment of these benefits.

As used in this booklet, the terms:

- "certificate" refers to this booklet describing the benefits directly funded through and provided by your employer;
- "insurance" and "insured" refers to the benefits directly funded through and provided by your employer;
- "plan", "we", "us" and "our" refer to the benefits that are directly funded through and provided by your employer, and are not insured by Guardian;
- "premium," "premiums," and "premium charge" refer to payments required from you for coverage under this plan; and
- "proof of insurability" refers to any evidence of your good health which may be required under this plan.

All terms and provisions, maximums or limitations set forth in this booklet will be applicable to these benefits provided by your employer.

B034.3327

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 UTICA UNIVERSITY .

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.

B034.2521

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.

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.

B034.2526

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

Enrollment Requirement: If You must pay all or part of the cost of Employee coverage, We will not cover You until You enroll in this Plan and agree to make the required payments. You will be considered a Late Entrant if You do this: (1) more than 31 days after the date You first become eligible; or (2) after You previously had coverage which ended because You failed to make a required payment.

B034.2579

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.

Once each year, during a special election period You may select to transfer to another dental expense option offered by your employer. Coverage under the new plan option starts of the first day of the month that follows election. Coverage under the former plan option ends on that date. If you transfer from one plan option to another plan option offered by Your Employer within this period Late Entrant penalties do not apply to You or Your eligible dependents.

As used here, "special election period" means a period agreed to by Your Employer and Us during which You can change dental plan elections.

Open enrollment period and special election periods may occur during the same time period.

B034.2638

All Options

If You initially waived dental coverage under this Plan because You were covered under another group dental plan and You now elect to enroll in the dental coverage under this Plan, You will not be considered a Late Entrant if Your 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 Employers rules.

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

The Probationary Service Period: If You are in an eligible class, You are eligible for dental coverage under this Plan after You complete the probationary service period, if any, established by the Employer.

Multiple Employment: If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple dental coverage under this Plan.

B034.2584

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 must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, or within 31 days of Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this more than 31 days after Your Eligibility Date, Your coverage is scheduled to start on the date You sign Your enrollment form.

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.

B034.2587

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.

B034.4478

All Options

ELIGIBILITY FOR DENTAL EXPENSE COVERAGE - DEPENDENT COVERAGE

B034.2605

All Options

Eligible Dependents For Dental Expense Coverage

Your eligible dependents are Your: (1) spouse; and (2) dependent children who are under age 20; and (3) dependent children who are enrolled as full-time students at accredited schools, from age 20, until they reach age 26.

An dependent child who is not able to remain enrolled as a full-time student due to a medically necessary leave of absence may continue to be an eligible dependent until the earlier of: (1) the date that is one year after the first day of the medically necessary leave of absence; or (2) the date on which coverage would otherwise end under this Plan. You must provide written certification by a treating physician which states: (a) that the child is suffering from a serious illness or injury; and (b) that the leave is medically necessary.

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

B034.2609

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

All Options

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

All Options

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.

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 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 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.

B034.2619

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 date You sign the enrollment form.

B034.2621

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, when he or she marries, or when Your dependent child or stepchild 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.

B034.2626-R

All Options

DENTAL EXPENSE INSURANCE COVERAGE

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 evidence of coverage includes form(s) which are the Plan's Schedule of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

B034.4155

All Options

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

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.

B034.2643

Option B

Covered Charges

Covered charges are the lesser of: (a) the provider's actual charges; and (b) the reasonable and customary charges for the dental services named 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.

By reasonable, we mean the charge is the Dentist's usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other Dentists. But, in no event will the covered charge be greater than the 10th percentile of the prevailing fee data for a particular service in a geographic area.

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. A covered charge for Orthodontic Treatment is incurred on the date the active orthodontic appliance is first placed. 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.

B034.2657

Option A

Covered Charges

Covered charges are the lesser of: (a) the provider's actual charges; and (b) the reasonable and customary charges for the dental services named 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.

By reasonable, we mean the charge is the Dentist's usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other Dentists. But, in no event will the covered charge be greater than the 10th percentile of the prevailing fee data for a particular service in a geographic area.

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.

B034.2659

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

All Options

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

All Options

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

Option B

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

Option A

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.

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.

B034.2723

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.

B034.2770

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 and services listed under the Other Surgical Procedures.

Injectable antibiotics needed solely for treatment of a dental condition.

B034.2850

Option B

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.

B034.2858

Option B

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

Option B

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

Option B

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 10 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.

B034.2734

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

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

Initial Election You may choose to be covered under one of the plans of dental expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your Election and pay the required premium.

B034.2927

Option B

Cash Deductible Benefit Year Cash Deductible for each Covered Person:

Group I Services	None
Group II and Group III Services	$50.00

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.

B034.2935

Option A

Cash Deductible Benefit Year Cash Deductible for each Covered Person:

Group I Services	None
Group II Services	$50.00

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.

B034.2943

Option A

Payment Rates Payment Rates for:

Group I Services	100%
Group II Services	50%

B034.3091

Option B

Payment Rates Payment Rates for:

For Group I Services 100%
For Group II Services 80%
For Group III Services 40%

B034.3093

Option B

Payment Limit

- Benefit Year Payment Limit $1,000.00

B034.3197

Option A

Payment Limit

- Benefit Year Payment Limit for Group I $750.00
- Benefit Year Payment Limit for Group II Services $750.00

B034.3200

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

Option B

CERTIFICATE RIDER - ORTHODONTIC TREATMENT - 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 rider amends this Plan by the addition of the following:

I. The Exclusions section is amended so that the exclusion of benefits for Orthodontic Treatment does not apply to the benefits provided by this rider.

II. The following coverage for Orthodontic Treatment is added.

Orthodontic Treatment Benefits

We pay benefits for covered charges for Orthodontic Treatment subject to the conditions described below, and to all of the other terms of this plan.

B034.3202

Option B

Cash Deductible

- Lifetime Cash Deductible for Orthodontic Treatment . . . . . None

B034.3204

Option B

Payment Rate

- Payment Rate for Orthodontic Treatment 50%

The Payment Rate is applied to covered charges. The covered charges for a service may be less than the provider's actual charge. See the Covered Charges section of this Plan for details.

B034.3207

Option B

Payment Limit Orthodontic Treatment Lifetime Maximum - up to $1,250.00

B034.3206

Option B

Covered Charges Subject to the terms of the Plan, we cover charges for the following services for Orthodontic Treatment.

Orthodontic Services Any covered Group I, Group II or Group III Service in connection with Orthodontic Treatment.

- Transseptal fiberotomy.
- Surgical exposure of impacted or unerupted teeth in connection with Orthodontic Treatment - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.
- Orthodontic records include exams, x-rays, diagnostic photographs, diagnostic casts or cephalometric films.
- Limited Orthodontic Treatment, interceptive Orthodontic Treatment, or comprehensive Orthodontic Treatment, including fabrication and insertion of any and all fixed Appliances and periodic visits.
- Orthodontic retention, including any and all necessary fixed and removable appliances and related visits: limited to initial Appliance(s) only.

A covered charge for Orthodontic Treatment is incurred on the date the Active Orthodontic Appliance is first placed.

Treatment Plan: A treatment plan should always be sent to us before Orthodontic Treatment starts.

B034.3208

Option B

Penalty For Late Entrants: During the first 12 months a Late Entrant is covered by this Plan, we will not cover charges for Orthodontic Treatment. Charges for such services cannot be used to meet the deductible. 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.

B034.3495

Option B

How We Pay Benefits For Orthodontic Treatment: This rider provides benefits for Orthodontic Treatment only for covered dependent children who are less than 19 years old when the Active Orthodontic Appliance is first placed.

We pay for covered charges for Orthodontic Treatment at the Payment Rate shown above.

Using the Covered Person’s original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (1) the proposed length of treatment; or (2) two years.

We make the initial payment when the active orthodontic Appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the Covered Person must remain covered by this rider. We limit what we pay for Orthodontic Treatment to the lifetime Payment Limit shown above. What we pay is based on all of the terms of this rider and the other terms of this Plan.

We do not pay benefits for orthodontic charges incurred by a Covered Person prior to being covered by this rider. We limit what we pay for Orthodontic Treatment started prior to a Covered Person being covered by this rider to charges determined to be incurred by the Covered Person while covered by this rider. Based on the original treatment plan, we determine the portion of charges incurred by the Covered Person prior to being covered by this rider, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the Orthodontic Treatment started.

The benefits we pay for Orthodontic Treatment will not be charged against a Covered Person's Benefit Year Payment Limits that apply to all other services.

If This Plan Replaces The Prior Plan: We reduce a Covered Person's orthodontic Payment Limit by the amounts paid or payable under the Prior Plan. The Covered Person must give us proof of the amounts applied toward the Prior Plan's payment limits.

After This Coverage Ends: We do not pay for charges incurred after a Covered Person's coverage ends. But, subject to all of the other terms of this Plan, we pay benefits for Orthodontic Treatment for 30 days after a person's coverage under this Plan ends.

Exclusions: In addition to the exclusions shown in the Plan, we will not pay benefits for the following with respect to Orthodontic Treatment:

- The repair of an orthodontic Appliance.
- The replacement of a lost or broken orthodontic retainer.

Definitions: In addition to the definitions shown in the Plan, the term "Active Orthodontic" means an Appliance, like a fixed or removable Appliance, braces or a functional orthotic used for Orthodontic Treatment to move teeth or reposition the jaw.

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

Michael Prestileo, Senior Vice President

B034.3216

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

Option B

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 $500.00

Rollover (if all benefits are for services provided by a Preferred Provider) $350.00

Rollover (if any benefits are for services provided by a Non-Preferred Provider) $250.00

Rollover Account Maximum $1,000.00

If this Plan's dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full Benefit Year. And, if the effective date of a Covered Person's dental coverage is in October, November or December, this rollover provision will not apply to the Covered Person until January 1 of the next 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

Michael Prestileo, Senior Vice President

B034.3243

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

Michael Prestileo, Senior Vice President

B034.4113

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

Michael Prestileo, Senior Vice President

B034.4116

EVIDENCE OF COVERAGE RIDER - Dependent Termination

This Rider amends the Evidence of Coverage as follows and is effective on the Policy Date. If this Rider is effective after the Policy Date, the Rider becomes effective on its issue date.

The **When Dependent Coverage Ends** provision is replaced in its entirety with the following:

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependent(s) as follows:

- When Your Employee coverage ends;
- When You stop being a member of a class of Employees eligible for such coverage;
- When this Evidence of Coverage ends, or dependent coverage is discontinued for a class of Employees to which You belong;
- On the last day of the period for which required payments are made for Your dependent(s);
- For Your child, on the last day of the month in which he or she attains the age limit or no longer qualifies under Continuing Coverage For Dependent Children Past the Age Limit.
- It also happens on the last day of the month in which Your child marries, or Your child or stepchild is no longer dependent on You for at least 50% of his or her support and maintenance.
- For Your Spouse, on the last day of the month in which Your marriage is lawfully terminated.
- On the date Your dependent dies.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage For Dependent Children Past the Age Limit

An unmarried child that meets all of the conditions below may continue coverage past the child age limit:

- The child must be incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the mental hygiene law) or physical handicap;
- The child must be primarily dependent upon You for support and maintenance;
- The child's mental illness, developmental disability, mental retardation or physical handicap must have begun before he or she reached the age limit; and

- The child must have been covered by this Evidence of Coverage, or the prior carrier's group plan that it replaced, before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.

You will have to send us documentation that your child meets these requirements within 31 days of the date the age limit was reached.

After two years has passed from the date the age limit was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Any coverage provided under this section ends when Your coverage ends, or your child no longer meets the conditions above.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B034.4504

Option B

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on the issue date.

This Rider amends the Certificate by replacing the Covered Charges provision with the new provision as shown below.

Covered Charges

Reimbursement will be based on Guardian's Reimbursement Schedule in the *dentist's* zip code for the dental services named 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.

Guardian's Reimbursement Schedule is calculated utilizing a combination of industry, third party and internal data. In no event will the covered charge be greater than the 90th percentile of the Guardian Reimbursement Schedule for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan,* these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. 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.

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 the Certificate.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B531.0821

GC-A-DG2000-20

Option A

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on the issue date.

This Rider amends the Certificate by replacing the Covered Charges provision with the new provision as shown below.

Covered Charges

Reimbursement will be based on Guardian's Reimbursement Schedule in the *dentist's* zip code for the dental services named 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.

Guardian's Reimbursement Schedule is calculated utilizing a combination of industry, third party and internal data. In no event will the covered charge be greater than the 90th percentile of the Guardian Reimbursement Schedule for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan,* these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan.* A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

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 the Certificate.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B531.0822

GC-A-DG2000-20

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

  UTICA UNIVERSITY Plan

- **Employer's Name:** (Plan Sponsor)

  UTICA UNIVERSITY

  Address: 1600 BURRSTONE RD
  UTICA NY 13502

  Phone Number: 315-792-3024

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**999999999

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

  UTICA UNIVERSITY

  Address: 1600 BURRSTONE RD
  UTICA NY 13502

  Phone Number: 315-792-3024

- **Agent for the Service of Legal Process:**

  UTICA UNIVERSITY

  Address: 1600 BURRSTONE RD
  UTICA NY 13502

  Phone Number: 315-792-3024

  (Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.

- **Date of End of Record Year:** January 1st .

- **Sources of Contribution:**Contributions to the plan are provided by:

  - the Employer

  - the Employee

  - Both the Employer and the Employee (assuming there are situations where both contribute).

- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)

- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.

- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.

- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0383

All Options

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.

B055.0081

All Options

The Guardian's Responsibilities

B055.0079

All Options

The dental expense benefits provided by this plan are funded solely by the employer. The benefits **are not** guaranteed by a policy of insurance issued by Guardian. Guardian does supply administrative services, such as claims services, including the payment of claims, preparation of employee benefit booklets, and changes to such benefit booklets.

B800.0064

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 Administrator with respect to processing claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

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

Appeal of Adverse Benefit Determinations

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

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

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

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

- 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.

B055.0066

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time.

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

B800.0068

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

Guardian

0000/9999/ /0001/Y70142/B/*EOD*