GUARDIAN™

YOUR GROUP INSURANCE
PLAN BENEFITS

ST LAWRENCE UNIVERSITY
LOW OPTION DENTAL, VISION ACCESS
The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.
CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

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<th>Group Policy No.</th>
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Issued To

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3

B110.0023
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GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this plan.

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

"Employer" means the employer who purchased this plan.


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

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

CGP-3-R-GENPRO-90

Limitation of Authority

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

CGP-3-R-LOA-90

Incontestability

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

No statement in any application made by a person insured under this plan shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his or her lifetime. The application must be signed by the covered person and a copy furnished to him or her or his or her beneficiary.

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

CGP-3-R- INCY-NY-01
Your right to make a claim for any accident and health benefits provided by this plan, is governed as follows:

**Notice**
You must send us written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include your name and plan number. If the claim is being made for one of your covered dependents, his or her name should also be noted.

**Proof of Loss**
We’ll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don’t furnish the forms on time, we’ll accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

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

**Late Notice of Proof**
We won’t void or reduce your claim if you can’t send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

**Payment of Benefits**
We’ll pay benefits for loss of income once every 30 days for as long as we’re liable, provided you submit periodic written proof of loss as stated above. We’ll pay all other accident and health benefits to which you’re entitled as soon as we receive written proof of loss.

We pay all accident and health benefits to you, if you’re living. If you’re not living, we have the right to pay all accident and health benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See “Your Accidental Death and Dismemberment Benefits” for how dismemberment benefits are paid.

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

**Limitations of Actions**
You can’t bring a legal action against this plan until 60 days from the date you file proof of loss. And you can’t bring legal action against this plan after three years from the date you file proof of loss.

**Workers’ Compensation**
The accident and health benefits provided by this plan are not in place of, and do not affect requirements for coverage by Workers’ Compensation.
An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87  B240.0064
Federal Continuation Rights

Important Notice

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

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

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

Under federal law, "marriage" means a legal union between one man and one woman as husband and wife, and "spouse" refers to a person of the opposite sex who is a husband or wife. This plan will allow an active, covered employee’s spouse of the same sex and that spouse’s dependent children to continue group health benefits under this provision only when: (a) the employer consents; and (b) that employee elects such continuation coverage.

Conversion

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person’s family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.
To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security’s determination of the disabled qualified continuee’s disability as described in "The Qualified Continuee’s Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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

CGP-3-R-COBRA-96-1

If You Die While Insured

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

CGP-3-R-COBRA-96-2

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee’s Responsibilities

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

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

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

Your Employer’s Responsibilities

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

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

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

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.
If a qualified continuee’s continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

**Your Employer’s Liability**

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

**Election of Continuation**

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

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

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

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

**Grace in Payment of Premiums**

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

**When Continuation Ends**

A qualified continuee’s continued group health benefits end on the first of the following:

1. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
Federal Continuation Rights (Cont.)

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent’s eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) the date the employer ceases to provide any group health plan to any employee;

(5) the end of the period for which the last premium payment is made;

(6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(7) the date, after the date of election, he or she becomes entitled to Medicare.

Uniformed Services Continuation Rights

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

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

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

Employee Coverage

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

Other Conditions
If you must pay all or part of the cost of employee coverage, we won’t insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this plan because you were covered under another group plan, and you now elect to enroll in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other plan ends due to one of the following events: (a) termination of your spouse’s employment; (b) loss of eligibility under your spouse’s plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

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

When Your Coverage Starts
Employee benefits are scheduled to start on your effective date.

But you must be actively at work on a full-time basis on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active full-time work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on a full-time basis on your last regularly scheduled work day.

When Your Coverage Ends
Your coverage ends on the last day of the month in which your active full-time service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

It also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all employees. And it ends when this plan is changed so that benefits for the class of employees to which you belong ends.
If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

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

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

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

Coverage may continue until the earliest of the following:

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

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

- **Contingency Operation**: This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

- **Covered Servicemember**: This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin**: This term means the nearest blood relative of the employee.

- **Outpatient Status**: This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness**: This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

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**Dependent Coverage**

**Eligible Dependents**

Your eligible dependents are: (a) your legal spouse; (b) your unmarried dependent children who are under age 19; and (c) your unmarried dependent children from age 19 until their 25th birthday, who are enrolled as full-time students at accredited schools.

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

Adopted And Step-Children
Your “unmarried dependent children” include your dependent legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible
We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

Handicapped Children
You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage’s age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage’s age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child’s condition continues. But, after two years, we can’t ask for this proof more than once a year.

The child's coverage ends when yours does.

Waiver Of Dental Late Entrants Penalty
If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse’s employment; (b) loss of eligibility under your spouse’s plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.
When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan, the date your dependent coverage starts depends on when you elect to enroll your initial dependents and agree to make any required payments.

If you do this on or before your eligibility date, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows your eligibility date and the date you become insured for employee coverage.

If you do this within the enrollment period, the coverage is scheduled to start on the date you become insured for employee coverage.

If you do this after the enrollment period ends, each of your initial dependents is a late entrant and is subject to any applicable late entrant penalties. The dependent's coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

Once you have dependent coverage for your initial dependents, you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the newly acquired dependent becomes eligible, the dependent’s coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the newly acquired dependent, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant’s coverage is scheduled to start on the date you sign the enrollment form.

Exception

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

Newborn And Adopted Children

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

We do this only if: (a) you are already covered for dependent child coverage when the child is born, adopted or placed for adoption; or (b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born, adopted or placed for adoption. If you fail to do this, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.
When Dependent Coverage Ends

Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

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

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

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

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

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.
CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee’s domestic partner will be eligible for dental coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other’s sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee’s state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee’s dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee’s death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart J Shaw
This page provides a quick guide to some of the Dental Expense Insurance plan features which people most often want to know about. But it’s not a complete description of your Dental Expense Insurance plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- **Benefit Year Cash Deductible for Non-Orthodontic Services**
  - For Group I Services: None
  - For Group II Services: $50.00 for each covered person

- **Payment Rates:**
  - For Group I Services: 100%
  - For Group II Services: 100%

- **Benefit Year Payment Limit for Non-Orthodontic Services**
  - For Group I and II Services: Up to $750.00

Once each year, during the group enrollment period, you may elect to enroll in one of the dental expense plan options offered by your employer. The group enrollment period is a time period agreed to by your employer and us. 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 they enroll during the group enrollment period.

Once each year, during a special election period you may select to transfer to another dental expense plan option offered by your employer. The special election period is a time period agreed to by your employer and us. 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.

The group enrollment period and the special election periods are time periods agreed to by your employer and us. Such open enrollment period and special election period may occur during the same time period.
DENTAL EXPENSE INSURANCE

This insurance will pay many of a covered person’s dental expenses. We pay benefits for covered charges incurred by a covered person. What we pay and terms for payment are explained below.

Covered Charges

Covered charges are 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.

We may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, we mean the charge is the dentist’s usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn’t more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

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

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

Appeals Process

External Appeal
Right To An External Appeal

As shown below, the covered person has a right to an external appeal of a denial of coverage. If we denied coverage on the basis that the service is not medically necessary or is an experimental or investigational treatment, the covered person or his or her representative may appeal that decision to an External Appeal Agent. "An External Appeal Agent" means an independent entity certified by the State to conduct such appeals.

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

If coverage has been denied on the basis that the service is not medically necessary, the covered person may appeal to an External Appeal Agent if he or she satisfies both of the following:

- The service, procedure or treatment must be covered by this plan; and
- The covered person must have received a final adverse determination through this plan's internal appeal process, and Guardian must have upheld the denial; or the covered person and Guardian must agree in writing to waive any internal appeal.

Right To Appeal A Determination That A Service Is Experimental Or Investigational

If coverage has been denied on the basis that the service is experimental or investigational, he or she must satisfy both of the following:

- The service must be covered by this plan; and
- The covered person must have received a final adverse determination through this plan's internal appeal process and Guardian must have upheld the denial; or the covered person and Guardian must agree in writing to waive any internal appeal.

The External Appeal Process

If, through this plan's internal appeal process, the covered person received a final adverse determination that upholds a denial of coverage on the basis that the service is not medically necessary or is experimental or investigational treatment, he or she has 45 days from receipt of such notice to file a written request for an external appeal. If the covered person and Guardian have agreed in writing to waive any internal appeal, he or she has 45 days from receipt of such waiver to file a written request for an external appeal. An external appeal application will be provided with the final adverse determination, or with the written waiver of an internal appeal.

The covered person may also request an external appeal application from New York State at 1-800-400-8882. He or she must complete the application and submit it to the State Department of Insurance at the address shown on the application. If the covered person meets the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

The covered person will be able to submit added documentation with his or her request. If the External Appeal Agent decides that the information the covered person submits shows a material change from the information on which we based our denial, the External Appeal Agent will share this information with us so that we can exercise our right to reconsider our decision. If we choose to do so, we have three business days to amend or confirm our decision. Please note that in the case of an expedited appeal, described below, we do not have a right to reconsider our decision.
In general, the External Appeal Agent must make a decision within 30 days of receipt of the covered person’s completed application. The External Appeal Agent may request more information from the covered person, his or her dentist or us. If the External Appeal Agent requests more information, it will have five more business days to make its decision. The External Appeal Agent must notify the covered person in writing of its decision within two business days.

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

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

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

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

The Covered Person’s Responsiblities

It is the covered person’s RESPONSIBILITY to initiate the external appeal process. The covered person may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. If the requested service has already been provided to the covered person, his or her dentist may file an external appeal application on the covered person’s behalf, but only if he or she has consented to this in writing.
Under New York State law, the covered person’s completed request for appeal must be filed within 45 days of either the date upon which the covered person receives written notification from us that we have upheld a denial of coverage, or the date on which he or she receives a written waiver of any internal appeal. Guardian has no authority to grant an extension of this deadline.

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

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

Proof of Claim

So that we may pay benefits accurately, the covered person or his or her dentist must provide us with information that is acceptable to us. This information may, at our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document proof of claim and support the necessity of the proposed treatment. If we don’t receive the necessary information, we may pay no benefits, or minimum benefits. However, if we receive the necessary information within 15 months of the date of service, we will redetermine the covered person’s benefits based on the new information. Failure to furnish such proof within such time will not invalidate or reduce any claim if it will be shown not to have been reasonably possible to furnish such proof and that such proof was furnished as soon as was reasonably possible.
Pre-Treatment Review

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

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person’s dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person’s condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won’t deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

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.

The Benefit Provision - Qualifying For Benefits

Penalty For Late Entrants

During the first 6 months that a late entrant is covered by this plan, we won’t pay for the following services:

- All Group II Services.
The Benefit Provision - Qualifying For Benefits (Cont.)

Charges for the services we don’t cover under this provision are not considered to be covered charges under this plan, and therefore can’t be used to meet this plan’s deductibles.

*We* don’t apply a late entrant penalty to covered charges incurred for services needed solely due to an injury suffered by a covered person while insured by this plan.

A late entrant is a person who: (a) becomes covered by this dental plan more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable payment rate.

A benefit year deductible of $50.00 applies to Group II services. Each covered person must have covered charges from this service group which exceeds the deductible before we pay him or her any benefits for such charges. These charges must be incurred while the covered person is insured.

Once a covered person meets the deductible, *we* pay for his or her Group II covered charges above that amount at the applicable payment rate for the rest of that benefit year.

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $750.00.

A covered family must meet no more than three individual benefit year deductibles in any benefit year. Once this happens, we pay benefits for covered charges incurred by any covered person in that covered family, at the applicable payment rate for the rest of that benefit year. The charges must be incurred while the person is insured. What *we* pay is based on this plan’s payment limits and to all of the terms of this plan.

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

- Benefits for Group I Services .................................................. 100%
- Benefits for Group II Services ................................................ 100%

*After This Insurance Ends*

*We* don’t pay for charges incurred after a covered person’s insurance ends.

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Special Limitations

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A covered person may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this plan. For the first twelve months that a covered person is covered by this plan, we won't pay for a dental prosthesis which replaces such teeth unless the dental prosthesis also replaces one or more eligible natural teeth lost or extracted after the covered person became covered by this plan.

If This Plan Replaces The Prior Plan

This plan may be replacing the prior plan you had with another insurer. If a covered person was insured by the prior plan and is covered by this plan on its effective date, the following provisions apply to such covered person.

- Teeth Extracted While Insured By The Prior Plan - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a covered person's dental prosthesis which replaces teeth: (a) that were extracted while the covered person was insured by the prior plan; and (b) for which extraction benefits were paid by the prior plan.

- Deductible Credit - In the first benefit year of this plan, we reduce a covered person's deductibles required under this plan, by the amount of covered charges applied against the prior plan's deductible. The covered person must give us proof of the amount of the prior plan's deductible which he or she has satisfied.

- Benefit Year Non-Orthodontic Payment Limit Credit - In the first benefit year of this plan, we reduce a covered person's benefit year payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan's payment limits.
Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this plan’s List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan.
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, or appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the “Other Oral Surgical Procedures” section of this plan.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera.
- Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis.
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation; that is incidental to or results from a medical condition.

Temporary or provisional dental prosthesis or appliances except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan.

Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.

Any service furnished solely for cosmetic reasons, unless the “List of Covered Dental Services” provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a dental prosthesis; (2) facings on a dental prosthesis for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty. Excluded cosmetic services do not include: (1) reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; (2) reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect; (3) care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; and (4) care or treatment necessary due to congenital disease or anomaly.

Replacing an existing appliance or dental prosthesis with any appliance or prosthesis; unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the covered person’s mouth in an injury suffered while insured, and can not be made serviceable.

A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.

The replacement of extracted or missing third molars/wisdom teeth.

Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.

Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Workers’ Compensation or similar laws.
Exclusions (Cont.)

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person’s employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.

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

- Orthodontic treatment.

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List of Covered Dental Services

The services covered by this plan are named in this list. Each service on this list has been placed in one of two groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services.

All covered dental services must be furnished by or under the direct supervision of a dentist. And they must be usual and necessary treatment for a dental condition.

CGP-3-DNTL-90-13  B490.0149

Group I - Preventive Dental Services
(Non-Orthodontic)

- Prophylaxis And Fluorides
  Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

  - Adult prophylaxis covered age 12 and older.

  Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient’s medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

  Fluoride treatment, topical application - limited to covered persons under age 19 and limited to 1 treatment(s) in any 6 consecutive month period.

- Office Visits, Evaluations And Examination
  Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

  Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.
Group I Preventive Dental Services (Cont.)
(Non-Orthodontic)

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

CGP-3-DNTL-90-14 B498.4802

Space Maintainers - limited to covered persons under age 16 and limited to initial appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed and Removable Appliances To Inhibit Thumbsucking - limited to covered persons under age 14 and limited to initial appliance only. Allowance includes all adjustments in the first 6 months after insertion.

CGP-3-1- B498.0164

Radiographs

Allowance includes evaluation and diagnosis.

Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

- Full mouth series, of at least 14 films including bitewings
- Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

- Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.
- Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.0165

Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of covered persons under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

CGP-3-DNTL-90-14 B498.0166

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services

Allowance includes examination and diagnosis.
Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each covered dental specialty in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the covered person is under age 19, and 36 months if the covered person is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - limited to anterior teeth only. Coverage for resins on posterior teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 24 consecutive month period. Stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth
Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture repairs, metal
- Denture repairs, acrylic
- Denture repair, no teeth damaged
- Denture repair, replace one or more broken teeth
- Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the dentist who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the reline is done by the dentist who furnished the denture. Limited to reline done more than 12 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the dentist who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

- Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
  - Pulp capping, direct
  - Pulp capping, indirect - includes sedative filling.
- Vital pulpotomy, only when root canal therapy is not the definitive treatment
- Gross pulpal debridement
- Pulpal therapy, limited to primary teeth only
- Root Canal Treatment
  - Root canal therapy
  - Root canal retreatment, limited to once per tooth, per lifetime
  - Treatment of root canal obstruction, no-surgical access
  - Incomplete endodontic therapy, inoperable or fractured tooth
  - Internal root repair of perforation defects
Other Endodontic Services
Apexification, limited to a maximum of three visits
Apicoectomy, limited to once per root, per lifetime
Root amputation, limited to once per root, per lifetime
Retrograde filling, limited to once per root, per lifetime
Hemisection, including any root removal, once per tooth

Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of one prophylaxis or periodontal maintenance procedure in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

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

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

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

Gingivectomy or gingivoplasty, per quadrant
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
Gingival flap procedure, including scaling and root planing, per quadrant
Distal or proximal wedge, not in conjunction with osseous surgery
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.
Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

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

Guided tissue regeneration, resorbable barrier or nonresorbable barrier Bone replacement grafts, when the tooth is present

Periodontal surgery related

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

Non-Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth
Root removal non-surgical extraction of exposed roots

Surgical Extractions

Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth
Other Oral Surgical Procedures

Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

- Alveoloplasty, per quadrant
- Removal of exostosis, per site
- Incision and drainage of abscess
- Frenulectomy, Frenectomy, Frenotomy
- Biopsy and examination of tooth related oral tissue
- Surgical exposure of impacted or unerupted tooth to aid eruption
- Excision of tooth related tumors, cysts and neoplasms
- Excision or destruction of tooth related lesion(s)
- Excision of hyperplastic tissue
- Excision of pericoronal gingiva, per tooth
- Oroantral fistula closure
- Sialolithotomy
- Sialodochoplasty
- Closure of salivary fistula
- Excision of salivary gland
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Vestibuloplasty

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this plan.

Injectable antibiotics needed solely for treatment of a dental condition.
Employee Vision Discount Program

An employee’s eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If an employee is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If an employee is not covered under this plan’s dental coverage, he or she is not eligible for this vision discount program.

An employee’s participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

An employee’s participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

CGP-3-EC-90-1.0

Dependent Vision Discount Program

An employee’s covered dependent’s eligibility for this vision discount program is contingent upon his or her eligibility for dental coverage under this plan.

If a dependent is covered for dental coverage under this plan, he or she is eligible for this vision discount program.

If the dependent is not covered under this plan’s dental coverage, he or she is not eligible for this vision discount program.

A dependent’s participation in this vision discount program starts on the later of: (a) the effective date of this program; or (b) the date he or she becomes covered for dental benefits under this plan.

The dependent’s participation in this vision discount program ends on the earlier of: (a) the date this program ends; or (b) the date he or she is no longer covered for dental benefits under this plan.

CGP-3-DEP-90-1.0
Discounts on Vision Services and Supplies

A member of this program can receive discounts on vision care services or supplies from a vision provider who is under contract with Davis Vision’s (Davis) network, as described below. Discounts are not available from providers who are not members of Davis network.

The member must pay the entire discounted fee directly to the Davis network doctor. There is no need to file a claim.

A member must make an appointment with a Davis network doctor. To find a Davis network doctor, the member can visit www.davisvision.com or call 1-877-393-7363.

When a person is no longer a member of this program, access to the network discounts ends.

The discounts provided by this program are as follows:

<table>
<thead>
<tr>
<th>Service</th>
<th>Average Discount</th>
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</thead>
<tbody>
<tr>
<td>Comprehensive eye exam</td>
<td>15% off usual charge</td>
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</table>

**Frames**

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<tbody>
<tr>
<td>Priced up to $70 retail</td>
<td>40%</td>
</tr>
<tr>
<td>Priced above $70 retail</td>
<td>28%</td>
</tr>
<tr>
<td>Lenses (uncoated plastic)</td>
<td>30%</td>
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<tr>
<td>Lens Options (add to lens prices above)</td>
<td>50%</td>
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</tbody>
</table>

**Contact Lenses**

<table>
<thead>
<tr>
<th>Service</th>
<th>Average Discount</th>
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<tbody>
<tr>
<td>Contract Lens examination</td>
<td>15% off usual charge</td>
</tr>
<tr>
<td>Conventional</td>
<td>20% off usual charge</td>
</tr>
<tr>
<td>Disposable/planned replacement</td>
<td>10% off usual charge</td>
</tr>
<tr>
<td>Laser Vision Correction</td>
<td>25% off usual charge</td>
</tr>
</tbody>
</table>

NOTE: Guardian is not the underwriter of this program and assumes no liability for the provision of services, the allowable discounts or the amount charged by the Davis network doctor.
CERTIFICATE AMENDMENT

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 the Dental Expense Insurance provisions of the Group Policy as follows:

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

The Guardian Life Insurance Company of America

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

CGP-3-A-DGOPT-10NY

B531.0051
**Important Notice**

This section applies to all group health benefits under this plan; except prescription drug and vision coverage, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

**Purpose**

When a covered person has health care coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

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**Definitions**

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Allowable Expense</strong></td>
<td>This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the plans is not an allowable expense. Examples of other expenses or services that are not allowable expenses are: If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is not an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms. If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans.</td>
</tr>
<tr>
<td><strong>Claim</strong></td>
<td>This term means a request that benefits of a plan be provided or paid.</td>
</tr>
<tr>
<td><strong>Claim Determination Period</strong></td>
<td>This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.</td>
</tr>
<tr>
<td><strong>Coordination Of Benefits</strong></td>
<td>This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.</td>
</tr>
<tr>
<td><strong>Custodial Parent</strong></td>
<td>This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.</td>
</tr>
</tbody>
</table>
Plan
This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group or group remittance subscriber contracts; (2) uninsured arrangements of group coverage; (3) group coverage through health maintenance organizations (HMOs) and other prepayment, group practice, and individual practice plans; (4) blanket contracts, except as shown below; (5) medical benefits under group or individual mandatory automobile "no-fault" and traditional mandatory automobile "fault" type contracts; and (6) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) direct payment subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice, and individual practice plans. This term also does not include: (i) blanket school accident type coverage or such coverages issued to a substantially similar group; or (ii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Primary Plan
This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

Secondary Plan
This term means a plan that is not a primary plan.

This Plan
This term means the group health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

Order Of Benefit Determination
The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.
When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

**Non-Dependent Or Dependent Child Covered Under More Than One Plan**

The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

But, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan that covers the person as a dependent; and primary to the plan that covers the person other than as a dependent (for example, as a retiree); then the order of payment between the two plans is reversed. In that case, the plan that covers the person as an employee, member, subscriber, or retiree is secondary and the other plan is primary.

The order of benefit determination when a child is covered by more than one plan is:

1. If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan’s coordination of benefits provision will determine which plan is primary.

2. If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

3. In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

**Active Or Inactive Employee**

The plan that covers a person as an active employee, or as that person’s dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person’s dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

**Continuation Coverage**

The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person’s dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.
Order Of Benefit Determination (Cont.)

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

Other
If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

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

When This Plan Is Secondary
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

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

Certain facts about health care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment

A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.

Right Of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

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

- we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to The Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery;

- we will be subrogated only to the extent of benefits paid by this plan because of that injury; and

- we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider:

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

- because of an injury to a covered person caused by a third party’s wrongful act or negligence; and

- which the covered person later recovers from the third party or the third party’s insurer.

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

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

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart J Shaw

CGP-3-SUBR-NY-92
For Group Plan No.: G-00482195-

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

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

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

Vision Expense Insurance (defined as Limited Benefits Health Insurance by the New York State Insurance Department)

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

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

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

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

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

**Covered Dental Specialty**
means any group of procedures which falls under one of the following categories, whether performed by a specialist dentist or a general dentist: restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

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

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

**Dental Prosthesis**
means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

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

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

**Eligible Dependent**
is defined in the provision entitled "Dependent Coverage."
Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this plan.

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

Employer means ST LAWRENCE UNIVERSITY.

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 36 hours per week), at his employer’s place of business.

Initial Dependents means those eligible dependents you have at the time you first become eligible for employee coverage. If at this time you do not have any eligible dependents, but you later acquire them, the first eligible dependents you acquire are your initial dependents.

Injury means all damage to a covered person’s mouth due to an accident which occurred while he or she is covered by this plan, and all complications arising from that damage. But the term injury does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.

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

Orthodontic Treatment means the movement of one or more teeth by the use of active appliances. It includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. This plan does not pay benefits for orthodontic treatment.
<table>
<thead>
<tr>
<th><strong>Glossary (Cont.)</strong></th>
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<tbody>
<tr>
<td><strong>Payment Limit</strong></td>
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<tr>
<td><strong>Payment Rate</strong></td>
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<td><strong>Posterior Teeth</strong></td>
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<td><strong>Proof Of Claim</strong></td>
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<td>CGP-3-GLOSS-90</td>
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<tr>
<td><strong>We, Us, Our And Guardian</strong></td>
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<tr>
<td>CGP-3-GLOSS-90</td>
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</tbody>
</table>
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.

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.

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

The Guardian is located at 7 Hanover Square, New York, New York 10004.
Group Health Benefits Claims Procedure

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

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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;
Group Health Benefits Claims Procedure (Cont.)

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and

- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person’s subordinate;

- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and

- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person’s subordinate.

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

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

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

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

**Alternative Dispute Options**

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

CGP-3-ERISA

B800.0076
Termination of This Group Plan

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

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

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