YOUR
GROUP INSURANCE
PLAN

HAART, INC
CLASS 0001
DENTAL

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

CERTIFICATE OF COVERAGE

Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B905.0011-R

TABLE OF CONTENTS

The forms listed below are attached to and made part of this certificate. The listed forms describe the coverages which the *Planholder* has elected.

All terms in italics are defined terms with special meanings. Definitions are shown in the Glossary or are defined where they are used.

GENERAL PROVISIONS

As used in this certificate:

"Accident and health" means any accidental death and dismemberment, dental, long term disability, short term disability or vision insurance provided by this *plan.*

"Covered person" means *you* insured by this *plan,* except in the "Repayment" section where "covered person" has a special meaning. See that section for details.

"Member" means a person who is enrolled in the Health Insurance Program (HIP) as administered by HAART, Inc.

"Planholder" means the entity who purchased this *plan,* in this case, HAART, Inc.

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

"Plan" means the *Guardian* group *plan* purchased by *your planholder,* except in the "Coordination of Benefits" section where "plan" has a special meaning. See that section for details.

"You," "your," and "certificateholder" mean a *member* covered by this *plan.*

B908.0007-R

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of *Guardian,* has the authority to act for *us* to: (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 *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.

Incontestability

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

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

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

Conformity with State Statute

The group *plan* is governed by the laws of the state of Louisiana. However, with respect to this certificate, any terms which are in conflict with any insurance statute or regulation of the jurisdiction where the *certificateholder* resides and which are applied regardless of where the policy is issued, are hereby amended to conform to the minimum requirements of such statute or regulation.

This provision will apply only to those *certificateholders* who are residents of that other jurisdiction and who are insured by the group *plan* on the date the claim for benefits is made.

B908.0037-R

Dental Claims Provisions

Your right to make a claim for any dental benefits provided by this *plan,* is governed as follows:

Notice Written notice of an injury or sickness for which a claim is being made must be given to *us* within 20 days of the date the injury occurs or the sickness starts. This notice should include *your* name and *plan* number.

We will not void or reduce a claim if notice is not given within the required time. But, notice must be given to *us* as soon as reasonably possible.

Claim Forms *We* will provide forms for filing proof of loss within 15 days of receipt of notice. But if *we* do not provide the forms on time, *we* will accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The nature and extent of the loss for which the claim is being made must be detailed.

Uniform Claim Forms All claim forms will be processed to conform with uniform claim form regulations issued by the Louisiana Department of Insurance.

Proof of Loss Written proof of loss must be furnished to *us* at *our* designated office.

This proof must be furnished within 90 days of the loss.

We will not void or reduce a claim if proof is not given within the required time. But, proof must be given as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

Payment of Benefits *We* will pay dental benefits as soon as *we* receive written proof of loss.

Unless otherwise required by law or regulation, *we* pay all dental benefits to *you* if *you* are living. If *you* or any other payee is not living, *we* have the right to pay all dental benefits, to one of the following: (a) *your* estate; (b) *your* spouse; (c) *your* parents; (d) *your* children; (e) *your* brothers and sisters; or (f) any unpaid provider of health care services.

When proof of loss is filed, *you* or any other payee 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 not require that a particular provider provide such care. And, *you* or any other payee may not assign *your* right to take legal action under this *plan* to such provider.

Time of Payment of Claims All claims will be paid within 30 days of receipt of written proof of loss in the forms required by the terms of the policy, unless just an reasonable grounds such as would put a reasonable and prudent businessperson on his or her guard, exist.

Legal Actions No legal action against this *plan* will be brought until 60 days from the date proof of loss has been given as stated above. And, no legal action will be brought against this *plan* after one year from the date written proof of loss is required to be given.

Workers' Compensation The dental benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

B908.0021

Repayment

We will not pay any benefits under this *plan,* to or on behalf of a *covered person,* who has received payment in whole from a *third party,* or its insurer for past or future dental charges, resulting from the negligence, intentional act, or no-fault tort liability of a *third party.*

If a *covered person* or his or her beneficiary makes a claim to *us* for dental charges, under this *plan* prior to receiving payment from a *third party* or its insurer, the *covered person* or his or her beneficiary must agree, in writing, to repay *us* from any amount of money they receive from the *third party,* or its insurer. But, this will only apply if the amount of money received fully compensates him or her for all damages he or she suffered. If the *covered person* or his or her beneficiary claims that the *covered person* was not fully compensated, he or she may be required to provide proof that the amount received did not equal full compensation.

The repayment will be equal to the amount of benefits paid by *us.* However, the *covered person* or his or her beneficiary may deduct the *reasonable pro-rata expenses incurred* in effecting the *third party* payment from the repayment to *us.*

The repayment agreement will be binding upon the *covered person* or his or her beneficiary whether: (a) the payment received from the *third party,* or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the *third party,* or its insurer, has admitted liability for the payment; or (c) the dental charges, are itemized in the *third party* payment.

As used in this provision:

"Covered person" means *you* or your dependent, including the legal representative of a minor or incompetent, insured by this *plan.*

"Reasonable pro-rata expenses" are those costs, such as lawyers fees and court costs, *incurred* to effect a third party payment, expressed as a percentage of such payment.

"Third party" means anyone other than *Guardian,* the *planholder* or the *covered person.*

B908.0034-R

GLOSSARY

This Glossary defines the italicized terms appearing in *your* certificate.

General Definitions

Active HIP Membership Or Active HIP Member means *you* are able currently eligible for and enrolled in HIP.

B941.0002-R

Definitions Applicable to Dental Expense Coverage

B941.0014

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

B941.0016

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

B941.0017

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

B941.0018

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.

B941.0020

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.

B941.0022

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 license or certificate and covered by this *plan.*

B941.0023

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.*

B941.0024

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.

B941.0025

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.

B941.0027

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

B941.0028

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

B941.0030

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

B941.0029

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

B941.0032-R

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

B941.0033

ELIGIBILITY FOR DENTAL EXPENSE COVERAGE

B934.0004-R

Member Coverage

Eligible Members

To be eligible for member coverage, *you* must be an active *member.* And *you* must belong to a class of *members* covered by this *plan.*

B934.0008-R

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on your effective date.

But *you* must be an *active HIP member* on that date. And *you* must have met all of the applicable conditions explained above, and any applicable waiting period. If *you* are not an *active HIP member* on that date, *we* will postpone *your* coverage until the date *you* return to *active HIP membership.*

B934.0014-R

When Your Coverage Ends

Your coverage ends on the date *you* cease *active HIP membership* for any reason. Such reasons include death, request for disenrollment from HIP, or loss of HIP eligibility.

It also ends on the date *you* stop being a member of a class of *members* eligible for insurance under this *plan,* or when this *plan* ends for all *members.* And it ends when this *plan* is changed so that benefits for the class of *members* 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 dental benefits for a limited time.

B934.0019-R

DENTAL HIGHLIGHTS

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** . . None

B935.0023

- **Payment Rates:**

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

B935.0047

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

For Group I, II and III Services . . . . . Up to $5,000.00

B935.0067

DENTAL BENEFITS

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

B936.0005

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 is not more than the usual charge made by most other *dentists.* But, in no event will the covered charge be greater than the 95th 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 will* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

B936.0187

Alternate Treatment

If a *covered person* receives a dental diagnosis from a *preferred provider* for which the *covered person* qualifies for a covered dental service under this *plan,* the *covered person* may choose either of the following:

1. The services covered by this *plan* for treatment of the condition diagnosed; or

2. An alternative type, form, or quality of a dental procedure to treat the diagnosed condition which procedure is of equal or greater price, provided that the *covered person* approves the alternate procedure in advance and in writing. For such alternate services or procedures, the *preferred provider* will be paid for the dental procedure as follows:

    a. We will pay the benefits due under this plan for the dental service covered by this plan for treatment of the condition diagnosed.

    b. The covered person will pay the difference between the amount this plan pays for the covered dental service and the amount of the chosen alternate service or procedure.

If a *covered person* receives a dental diagnosis from either a *preferred provider* or a *non-preferred provider* for which the *covered person* qualifies for a covered dental service under this *plan,* and, if more than one type of covered service can be used to treat the diagnosed 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.

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* do not 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.

B936.0007

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

B936.0009

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 planholder. *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.

B936.0011-R

The Benefit Provision - Qualifying for Benefits

B936.0012

How We Pay Benefits for Group I, II and III Non-Orthodontic Services

We pay for Group I, II and III covered charges at the applicable *payment rate.*

B936.0073

All covered charges must be incurred while insured. *We* limit what *we* pay each *benefit year* to $5,000.00. What *we* pay is based on all of the terms of this *plan.*

B936.0083

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

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

B936.0149

After This Insurance Ends

We do not pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan, we* will pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis,* if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

B936.0157

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. This includes, but is 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. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *appliance* or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply 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. This includes 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.
- Temporary or provisional *dental prosthesis* or *appliances.* But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis;* and (2) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 3 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.
- Treatment of congenital or developmental malformations; or the replacement of congenitally missing 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).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* planholder, 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.*

B936.0526-R

List of Covered Dental Services

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

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

B936.0252

Group I - Preventive Dental Services

(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to 1 prophylaxis in any 3 consecutive month period, to a maximum of 4 total prophylaxis and periodontal maintenance cleanings in any 12 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Periodontal maintenance procedure - limited to one periodontal maintenance procedure in any 3 consecutive month period, to a maximum of 4 total prophylaxis and periodontal maintenance procedures in a 12 consecutive month period. Allowance includes periodontal charting, scaling and polishing.

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

Fluoride treatment, topical application - limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 3 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

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

B936.0808

Space Maintainers

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

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

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

Fixed And Removable Appliances

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

B936.0258

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

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 36 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

B936.0259

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

B936.0567

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

B936.0481

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 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.

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

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

Stainless steel prefabricated resin, and resin based composite - limited to once per tooth in any 24 consecutive month period. Stainless steel, prefabricated resin 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.

B936.0879

Crown and Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

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

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

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

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

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

B936.0264

Basic Restorative Services

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury,* and only when the tooth cannot be restored with amalgam or composite filling material. Facings on *dental prostheses* for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or *injury.* Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

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

Inlays
Onlays, including inlay
Labial veneers
Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

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

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

Crown or core buildup, including pins

B936.0268

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

B936.0271

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.

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.

B936.0551

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.

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

B936.0273

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

B936.0277

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, and services listed under the "Other Oral Surgical Procedures" section of this *plan.*

Injectable antibiotics needed solely for treatment of a dental condition.

B936.0279

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on *dental prostheses* for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

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

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal
3/4 cast metal crowns
3/4 porcelain crowns

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance.*

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth

Upper, resin base, including any conventional clasps, rests and teeth

Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Lower, resin base, including any conventional clasps, rests and teeth

Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Interim partial denture (stayplate), upper or lower, covered on anterior teeth only

Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

B936.0294

Coordination of Benefits

Purpose of this Provision

A person may be covered for dental expense benefits by more than one *plan.* For instance, he or she may be covered by *this plan* as a *member* and by another plan as a dependent of his spouse. If he or she is, this provision allows *us* to coordinate what *we* pay with what another *plan* pays. *We* do this so the *covered person* does not collect more in benefits than he or she incurs in charges.

Definitions

As used in this provision:

"Plan" means any of the following that provides health expense benefits or services: (A) group, blanket, or franchise insurance plans; (B) group Blue Cross plans, group Blue Shield plans, or other service or prepayment plans on a group basis; (C) union welfare plans, planholder plans, member benefits plans, trusteed labor and management plans, or other plans for members of a group; (D) group or group-type hospital indemnity benefits which exceed $100.00 per day; (E) programs or coverages required or provided by law, including Medicare or other governmental benefits; or (F) medical benefits provided by a group or group-type automobile "no-fault" and traditional "fault type" contracts.

"Plan" does not include coverage under individual or family policies or contract, school accident-type coverages, Medicaid or any other government program or coverage which *we* are not allowed to coordinate with by law. "Plan" also does not include group or group-type hospital indemnity benefits of $100.00 per day or less. schedule.

"This plan" means all dental expense benefits under this plan.

"Member" means the person who receives a certificate or other proof of coverage from a *plan* that covers him or her for health expense benefits.

"Dependent" means a person who is covered by a *plan* for health expense benefits, but not as a *member.*

"Allowable expense" means any necessary, reasonable, and usual expense for health care incurred by a *member* or dependent under both *this plan* and at least one other *plan* . When a *plan* provides service instead of cash payment, *we* view the reasonable cash value of each service as an allowable expense and as a benefit paid. *We* also view benefits payable by another *plan* as an allowable expense and as a benefit paid, whether or not a claim is filed under that *plan.*

"Claim determination period" means a calendar year in which a *member* or dependent is covered by *this plan* and at least one other *plan* and incurs one or more allowable expense under such *plans.*

How this Provision Works

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

In order to apply this provision, one of the *plans* is called the primary plan. All other *plans* are called secondary plans. The primary plan pays first, ignoring all other plans. The secondary plans then pay the remaining unpaid allowable expenses, but no *plan* pays more than it would have without this provision.

If a *plan* has no coordination provision, it is primary. But, during any claim determination period, when *this plan* and at least one other *plan* have coordination provisions, the rules that govern which *plan* pays first are as follows:

(A) A *plan* that covers a person as a *member* pays first; the *plan* that covers a person as a dependent pays second;

(B) A *plan* that covers a person as an active member or as a dependent of such member pays first. A *plan* that covers a person as a laid-off or retired member or as a dependent of such member pays second.

But, if the plan that *we* are coordinating with does not have a similar provision for such persons, then (B) will not apply.

(C) Except for dependent children of separated or divorced parents, the following governs which *plan* pays first when the person is a dependent of a *member:*

A *plan* that covers a dependent of a *member* whose birthday falls earliest in the calendar year pays first. The *plan* that covers a dependent of a *member* whose birthday falls later in the calendar year pays second. Except that if both *members* have the same birthday, the plan which has covered a *member* for the longer time pays first. The *member's* year of birth is ignored.

But, if the *plan* that *we* are coordinating with does not have a similar provision for such persons, then (C) will not apply and the other *plan's* coordination provision will determine the order of benefits.

(D) For a dependent child of separated or divorced parents, the following governs which *plan* pays first when the person is a dependent of a *member:*

(1) When a court order makes one parent financially responsible for the dental care expenses of the dependent child, then that parent's *plan* pays first.

(2) If there is no such court order, then the *plan* of the natural parent with custody pays before the *plan* of the stepparent with custody.

(3) The *plan* of the stepparent with custody pays before the *plan* of the natural parent without custody.

If rules (A), (B), (C) and (D) do not determine which *plan* pays first, the *plan* that has covered the person for the longer time pays first.

If, when *we* apply this provision, *we* pay less than *we* would otherwise pay, *we* apply only that reduced amount against payment limits of *this plan.*

Our Right to Certain Information

In order to coordinate benefits, *we* need certain information. A *covered person* must supply *us* with as much of that information as he can. But if he or she can not give us all the information *we* need, *we* have the right to get this information from any source. And if another insurer needs information to apply its coordination provision, *we* have the right to give that insurer such information. If *we* give or get information under this section *we* can not be held liable for such action.

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

Small Claims Waiver

We do not coordinate payments on claims of less than $50.00. But if, during any *claim determination period,* more *allowable expenses* are incurred that raise the claim above $50.00 *we* will count the entire amount of the claim when *we* coordinate.

B936.0305-R

CERTIFICATE AMENDATORY RIDER

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

The What You Can Do If You Have a Complaint or Grievance provision is added as follows:

What You Can Do If You Have a Complaint or Grievance

If you have a complaint or grievance, you can call us at 800-541-7846 and we will provide you with instructions on how to file your complaint or grievance.

If you have a grievance, it means that you are not satisfied with a service or claims response under this Plan. If you or someone you choose files a grievance and we do not send you a written decision within 30 days or we make an adverse benefit determination, you have the right to file a request for an external review by a dental professional that is not associated with us within 180 days. An external review is available when the adverse determination involves an issue of medical necessity, appropriateness, dental care setting, level of care, or effectiveness.

The External Review provision is added as follows:

External Review

We will complete a preliminary review within five business days of receiving your request to determine if all of the following have been met:

- You were covered at the time the dental service or treatment was requested or provided.
- The dental service or treatment is the subject of an adverse determination.
- You have exhausted our internal grievance and appeals process.
- All the required information and forms were provided.

We will provide written notification to the Louisiana Department of Insurance (DOI) and you within five business days of completing the preliminary review. If your request is not complete, the notice will include the information or materials needed to complete the request. If the request is not eligible, the notice will include the reasons for its ineligibility and your right to appeal to the Louisiana DOI.

If your request is complete and eligible, we will notify the Louisiana DOI. The Louisiana DOI will assign an Independent Review Organization (IRO) to complete the review. The assigned IRO will provide a written notice of the decision to uphold or reverse the adverse determination within 45 days of receipt of the request.

If the decision is made to reverse the adverse determination, we will immediately approve the coverage or payment that was subject to the adverse determination.

Requests for external review are limited to claims exceeding $250.

If you do file a request for an external review, you will need to authorize the release of any medical records that may be needed to make a decision about your grievance.

The Expedited External Review provision is added as follows:

Expedited External Review

You can file a request for an expedited external appeal at the same time as your request for external review if one of the following applies:

- You have a condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.
- The adverse determination concerns an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility.
- The adverse determination involves denial of coverage based on reason that treatment is experimental or investigational.

The assigned IRO will determine whether you will be required to complete the expedited external review of the grievance prior to conducting the external review.

You also have the right to contact the Louisiana DOI for assistance.

Louisiana Department of Insurance
1702 N. 3rd Street
Baton Rouge, LA 70802
800-259-5300 (Toll Free within Louisiana)
225-342-5900

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B936.1279

CERTIFICATE AMENDMENT

1. Under the Covered Charges provision, the following paragraphs are revised to read:

"By reasonable, *we* mean the charge is the *dentist's* usual charge for the service furnished. By usual, *we* mean the charge that he or she most frequently makes for that service. By customary, *we* mean the charge made for the given dental condition is not more than the usual charge made by most other *dentists.* But, in no event will: (1) the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area; or (2) the covered charge be less than the payment made to a *preferred provider. We* update the prevailing fee data twice each year. To do this, *we* use a national service that compiles amounts charged for each specific service based on the American Dental Association codes and the *dentist's* zip code. If there is not enough information to obtain a specific percentil in a geographic area, *we* use national data."

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

B942.0023

CERTIFICATE AMENDMENT

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

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.

B942.0016-R

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

CERTIFICATE AMENDMENT

This rider amends this Plan to provide additional services as described below.

ADDITIONAL SERVICES

Guardian has arranged to make available selected services for eligible Guardian policyholders and/or covered persons who may be entitled to receive certain services and supplies from various companies.

The additional services and supplies identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian assumes no liability for the services or supplies provided under these programs, nor for the amounts charged by the companies providing such service and supplies.

Policyholders and covered persons will be provided with complete details regarding available services and supplies; associated fees or charges; discounts; eligibility requirements; and conditions, terms and limitations and a telephone number to call with questions about the service.

The policyholder and covered persons may be eligible for the following service(s) and/or discounts:

- Financial Planning and Wellness Services.

When this plan ends, access to the services ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for a service, access to that service ends for the policyholder and for all persons covered under the plan.

When a covered person's coverage under this plan ends, access to the service ends for that person. When a covered person no longer meets the conditions for eligibility for a service, access to that service ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B942.0039

ERISA

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the member 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 planholder, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of a member 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 member and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

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

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

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

B800.0094-R

The Guardian's Responsibilities

B800.0048

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

B800.0064-R

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

B800.0049

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

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

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

In addition to the basic claim procedure explained in your benefit booklet, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of member 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;
- 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.

B800.0081-R

Termination of This Group Plan

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

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

B800.0068-R

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You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of your claim
- Print forms and plan materials
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