



GUARDIAN<sup>SM</sup>

**YOUR GROUP INSURANCE  
PLAN BENEFITS**

HEALTHPASS INSURANCE TRUST  
CLASSES 4 & 5/OPTION G - GOLD WITH DHMO FOR  
PLANS 369397, 369398, 369399, 369400, 369401,  
369402, 369403, 369404, 369405, 369406, 369407  
AND 369408

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.

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**CERTIFICATE OF COVERAGE**

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**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.

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 The Guardian.



Vice President, Group Products

CGP-3-R-STK-90-3

B110.0023-R



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## **SECTION I: Non-Managed DentalGuard Insurance**

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**This part of your booklet does not apply to your plan of Managed DentalGuard dental care expense insurance.**

**Your Managed DentalGuard dental care expense insurance plan appears later in this booklet.**

B850.0181-R



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## GENERAL PROVISIONS

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As used in this booklet:

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

"Covered person" means an employee insured by this *plan*.

"Employer" means the *employer* who purchased this *plan*.

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

"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

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### 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

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### Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90

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### Accident and Health Claims Provisions

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.

## Accident and Health Claims Provisions (Cont.)

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**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. You must send us written proof within 90 days of the loss.

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 90 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.

CGP-3-R-AHC-90

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## ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

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### Employee Coverage

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**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*.

Your eligibility for Life and AD&D coverage under this *plan* is contingent upon your eligibility for Disability coverage under this *plan*. If you elect Disability coverage under this *plan*, you must elect Life and AD&D coverage under this *plan*. If you are not insured for Disability coverage under this *plan*, you are not eligible for Life and AD&D coverage under 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 also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

CGP-3-EC-90-1.0

B264.0734-R

**When Your Coverage Starts** Subject to all of this *plan's* conditions of eligibility set forth below; your Life and AD&D coverage under this *plan* starts on the later of: (a) the effective date of this *plan*; and (b) the date you become insured for Disability coverage under this *plan*.

*Employee* benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

*Employee* benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be actively at work on a *full-time* basis on the scheduled effective date or dates. 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 any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

## Employee Coverage (Cont.)

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Sometimes, the effective date shown on the sticker or in the endorsement 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.

CGP-3-EC-90-2.0

B264.0790-R

### **Delayed Effective Date For Employee Optional Life Coverage**

With respect to this *plan's* employee optional group term life insurance, if an *employee* is not actively at work on a *full-time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury*, we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97

B270.0384-R

### **When Your Coverage Ends**

Your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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.

Your life and dismemberment coverage ends on the date you are no longer eligible for long term disability coverage under this *plan*.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0

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## GROUP TERM LIFE INSURANCE SCHEDULE

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### Employee Optional Contributory Term Life Insurance

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**Optional Life Election** You may choose to be insured under the plan of optional term life insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90

B265.0799-R

**Your Optional Term Life Insurance Amount** *Plan A* \$50,000.00

CGP-3-R-SCH-90

B265.0061-R

**Reduction of Optional Life Insurance Amount Based on Age** If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90

B265.0520-R

**Proof of Insurability Requirements** Proof of insurability requirements apply to your optional term life insurance. Such requirements may apply to your full benefit amount or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-3-R-SCH-90

B265.0431-R

We require *proof* before we will insure any *employee* who enrolls for optional term life insurance after the time allowed for enrolling as specified in this *plan*.

## Employee Optional Contributory Term Life Insurance (Cont.)

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We require *proof* for amounts of optional term life insurance in excess of \$10,000.00, if an *employee's* scheduled optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90

B265.0697-R

We require *proof* for all amounts of optional term life insurance, if an *employee's* scheduled optional term life effective date is after he or she reaches age 70.

CGP-3-R-SCH-90

B265.0702-R

## Employee Voluntary Accidental Death and Dismemberment Insurance (AD&D)

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**Voluntary AD&D Enrollment Period** You may choose to be insured under the plan of voluntary AD&D insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90

B265.0926-R

**Your Voluntary AD&D Insurance Amount** *Plan A* \$100,000.00  
CGP-3-R-SCH-90 B265.0244-R

### Spousal Education and Retraining Benefit

**Lifetime Maximum Benefit** \$20,000

**Maximum Number Of Benefit Payments** Full-Time Post Secondary Education . . . . . 8  
Part-Time Post Secondary Education . . . . . 4

CGP-3-R-SCH-90

B265.0849-R

### Dependent Child Education Benefit

**Lifetime Maximum Benefit** \$20,000.00 per eligible dependent

**Maximum Number Of Benefit Payments** 8 per lifetime per eligible dependent

**Maximum Benefit Period** 6 years from the date the first education benefit is made; per eligible dependent.

CGP-3-R-SCH-90

B265.0850-R

**Reduction of Voluntary AD&D Amount Based on Age** If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

## Employee Voluntary Accidental Death and Dismemberment Insurance (AD&D) (Cont.)

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The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90

B265.0531-R

### **Proof of Insurability Requirements**

Proof of insurability requirements apply to your voluntary AD&D insurance. Such requirements may apply to your full *benefit amount* or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-3-R-SCH-90

B265.0444-R

We require *proof* before we will insure any *employee* who enrolls for voluntary accidental death and dismemberment insurance after the time allowed for enrolling as specified in this *plan*.

CGP-3-R-SCH-90

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**Your Optional Group Term Life Insurance**

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- Life Benefit** Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the *plan* of benefits you have elected. Your benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit *proof of insurability* to us, and we approve it in writing. These requirements are also shown in the schedule.
- Proof Of Death** Subject to all of the terms of this *plan*, we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.
- Suicide Exclusion** We pay no benefits if your death is due to suicide, if such death occurs within two years from your optional group term life insurance effective date under this *plan*. Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase.
- Seatbelt And Airbag Benefits** If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by \$10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional \$5,000.00, for a total increase of \$15,000.00. However, in no event will the total increase exceed 10% of your optional group term life insurance benefit.
- Your Beneficiary** You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving the employer written notice, unless you've assigned this insurance. But the change won't take effect until the employer receives written notice.
- If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.
- If there is no beneficiary when you die, we'll pay the insurance to one or more of the following surviving relatives, in the order specified: (a) your spouse; (b) your parents; (c) your children; or (d) your brothers and sisters. We'll pay the insurance to your estate if there are no such surviving relatives.
- Assigning This Life Insurance** If you assign this insurance, you permanently transfer all of your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

## Your Optional Group Term Life Insurance (Cont.)

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by us.

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this plan before we receive and approve any assignment.

We suggest you speak to a lawyer before he or she makes any assignment. If you decide you want to assign this insurance, write to us for details.

**Payment To A Minor Or Incompetent** If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports the beneficiary.

**Payment Of Funeral Or Last Illness Expense** We have the option of paying up to \$500.00 of this insurance to any person who incurs expenses for your funeral or last illness.

**Settlement Option** If you or your beneficiary asks us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-EOPT-NY-00

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**THE FOLLOWING PROVISION APPLIES TO YOUR OPTIONAL GROUP TERM LIFE INSURANCE:**

### Converting This Group Term Life Insurance

**If Employment or Eligibility Ends** The employee's group life insurance ends if his employment ends, or if he stops being a member of an eligible class of employees. If either happens, he can convert all or part of his group life insurance to an individual life insurance policy.

**If the Group Plan Ends or Group Life Insurance is Dropped** The employee's group life insurance also ends if this group plan ends, or if group life insurance is dropped from the group plan for all employees or for his class. But, the amount he can convert is limited to the amount of his group insurance under this plan, less any group life benefits he becomes eligible for in the 45 days after this insurance ends.

**If the Group Life Insurance is Reduced** If the employee's group life insurance is reduced for the reasons explained below, the employee can convert the amount by which his group life insurance was reduced to an individual life insurance policy. The employee has this right to convert if his group life insurance is reduced:

- (1) on account of age, provided: (i) the first reduction occurs on or after he reached age 60; and (ii) the reduction equals at least 20% of the employee's last in-force pre-reduced group life insurance amount.
- (2) due to a change in class which causes a reduction; or
- (3) due to an amendment of the group plan which causes a reduction.

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## Converting This Group Term Life Insurance (Cont.)

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- The Converted Policy** The employee can convert to one of the policies we normally issue. It can't include disability benefits. And, it can't be a term policy. But, it can be preceded by single premium term insurance for up to one year.
- The premium for the converted policy will be based on: (a) the employee's standard or sub-standard risk and rate class under this plan; and (b) his age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion.
- How and When to Convert** To get a converted policy under this section, the employee must apply to us in writing and pay the required premium. He has 31 days after his group life insurance ends to do this. We won't ask for proof that he's insurable.
- But the employer must pay a premium, to us, for the 31 days of extended coverage, if: (1) the employer voluntarily ended the group plan; and (2) the employer replaces the terminated coverage within 6 months of its termination.
- Death During the Conversion Period** If an employee dies in the 31 days allowed for conversion under this section, we'll pay his beneficiary the amount he could have converted. We'll pay whether or not he applied for conversion.
- Notice of Conversion Right** If the employee is entitled to obtain a converted policy under this section, the employer must give the employee written notice of such right. The employer must give the employee the notice in person, or mail it to his last known address.
- This notice should be given within 15 days before or after the group life coverage ends. If the notice isn't given at the proper time, the employee will have 45 days from the date the notice is given to apply for the converted policy and pay the required premium. But, whether or not the notice is given, the extra time won't extend more than 90 days past the period otherwise allowed for the employee to convert.

CGP-3-R-LCON-NY-86

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## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits

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- The Choices** You may elect to be insured for any of the plans of employee voluntary accidental death and dismemberment with catastrophic loss (ADDCL) insurance offered by the employer. These plans are shown in the schedule. However, you can only be insured under one plan at a time. You must notify the employer of your election and pay the required premium.
- You may switch to another plan of benefits at any time, subject to any of this plan's proof of insurability requirements. You must notify the employer of any desired switch.
- The Benefit** We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 90 days of the date of the accident.

## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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**Covered Losses** Benefits will be paid according to the plan you have elected, only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

### ACCIDENTAL DEATH AND DISMEMBERMENT

<b>Covered Loss</b>	<b>Benefit</b>
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

### CATASTROPHIC LOSS BENEFITS

<b>Covered Loss</b>	<b>Benefit</b>
Quadriplegia (total paralysis of upper and lower limbs, bilaterally)	100% of Insurance Amount
Loss of speech and hearing (both ears)	100% of Insurance Amount
Loss of cognitive function	100% of Insurance Amount
Comatose state, in excess of one month	100% of Insurance Amount
Hemiplegia (total paralysis of upper and lower limbs, unilaterally)	50% of Insurance Amount
Paraplegia (total paralysis of both lower limbs)	50% of Insurance Amount
Loss of speech or hearing (both ears)	50% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident, except under the Common Carrier, Seatbelt and Airbag Benefit, and Repatriation Benefit provisions.

Loss of:

- (a) cognitive function means a significant decline or loss in intellectual aptitude. Such loss must result from an accidental injury. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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- (b) a hand or foot means it is completely cut off at or above the wrist or ankle.
- (c) sight means the total and permanent loss of sight.
- (d) speech or hearing means that speech or hearing is lost entirely.

**Payment Of Benefits** For covered loss of life, we pay the beneficiary described below.  
For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary described below.  
We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

**The Beneficiary** You decide who gets this insurance if you die. You should have named a beneficiary on your enrollment form. You can change your beneficiary at any time by giving us notice, unless you have assigned insurance. But the change won't take effect until we give you confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, your insurance will be divided equally by the beneficiaries still alive, unless you tell us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

CGP-3-R-ADCL1-00

B310.0401-R

**Seatbelt And Airbag Benefits** If you die as a direct result of a motor vehicle accident while properly wearing a seatbelt, we will increase your benefit by \$10,000.00. And if you die as a direct result of a motor vehicle accident while both: (a) properly wearing a seatbelt; and (b) sitting in a seat equipped with an airbag; we'll increase your benefit by another \$5,000.00, for a total increase of \$15,000.00. This benefit will be applied after the Common Carrier provision.

**Common Carrier** If your loss is due to an accident which occurs while you are riding in a public conveyance, we increase the benefit payable. We pay two times the amount which otherwise applies to such loss. But, you must have been a fare-paying passenger.

**Repatriation Benefit** For covered loss of life due to an accident which occurs at least 75 miles from your home, we pay an extra sum. We pay up to \$5,000.00 for costs to prepare and transport your body to a mortuary chosen by you or an authorized agent.

**Exclusions** We won't pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;

## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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- by declared or undeclared war or act of war or armed aggression;
- by service in the armed forces; or
- by your being intoxicated or under the influence of any narcotic, unless administered on the advice of a physician.

CGP-3-R-ADCL2-00-NY

B310.0440-R

### SPOUSAL EDUCATION AND RETRAINING BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay a spousal education and retraining benefit subject to all the terms below.

#### **When And How The Spousal Education And Retraining Benefit Begins**

We will pay a spousal education and retraining benefit when all of the following conditions are met:

- (a) a benefit is payable under this plan's Employee Voluntary Accidental Death and Dismemberment with Catastrophic Loss (ADDCL) Benefit, due to a specified loss; and
- (b) we receive proof of the spouse's enrollment in an institute of higher learning. The spouse must: (i) be enrolled on the date of the accidental injury which results in the specified loss; or (ii) enroll within 12 months of this date.

**Specified Loss** means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Institute of Higher Learning** includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

#### **What We Pay**

Subject to all the terms of this plan, the Spousal Education and Retraining Benefit per academic term is equal to the lesser of: (i) the spouse's net tuition expense for the term; (ii) 5% of the Employee Voluntary ADDCL Benefit paid as a result of the specified loss; and (iii) \$2,500.00.

**Tuition Expense** means charges incurred for courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

**Net Tuition Expense** means tuition expense less any scholarships or grants to which the spouse is entitled.

We pay this benefit to the person who has primary responsibility for these expenses.

## **Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)**

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This benefit is paid per academic term. Benefit duration is based on whether the spouse is enrolled in a part-time or full-time course of study. See the Employee Voluntary Accidental Death and Dismemberment Insurance Schedule.

**Alternative Minimum Benefit** If you suffer a specified loss but all the requirements for the spousal education and retraining benefit are not met, we will pay a one time flat benefit of \$2,000 to you if you are living. If not, we pay the beneficiary named on your enrollment form. If there is no beneficiary when you die, we will pay the benefit to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters. We completely discharge our liability for payment of the spousal education and retraining benefit with payment of the alternative minimum benefit.

**Continued Eligibility For The Spousal Education And Retraining Benefit** We require periodic proof of the spouse's continued enrollment in an institute of higher learning. The spouse must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent. We also require proof, per academic term, of: (a) the spouse's tuition expenses; and (b) any scholarships and grants the spouse is entitled to.

**When The Spousal Education And Retraining Benefit Ends** The spousal education and retraining benefit ends on the earliest of the following dates:

- (a) the date the spouse is no longer enrolled in an institute of higher learning;
- (b) the date the spouse fails to maintain a minimum grade point average as required above;
- (c) the date the spouse fails to furnish proof as required above;
- (d) the date the lifetime maximum benefit amount, shown in the schedule, is reached; and
- (e) the date the maximum number of benefit payments, shown in the schedule, is reached.

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### **DAY CARE EXPENSE BENEFIT**

If you suffer a specified loss due to an accidental bodily injury, we will pay a Day Care Expense Benefit subject to all the terms below.

**Eligibility For The Day Care Expense Benefit** This plan provides a day care expense benefit when all of the following conditions are met:

- (a) a benefit is payable under this plan's Employee Voluntary Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss; and
- (b) we receive proof of a qualified dependent's enrollment in a qualified day care program. Such enrollment must commence within 12 months of the date of the specified loss.

## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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**Specified Loss** means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury, resulting in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury resulting in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Qualified Dependent:** For purposes of the Day Care Expense Benefit a qualified dependent is: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) dependent upon you for main support and maintenance; and (c) under the age of seven on the date of the accidental injury which results in the specified loss.

**Qualified Day Care Program:** means a program of child care which: (i) is provided in a facility that is licensed as a day care center; or (ii) is operated by a licensed day care provider; and (iii) charges a fee for the care of children. A qualified day care program does not include child care provided by a parent, step-parent, grandparent, sibling, aunt or uncle.

**What We Pay** Subject to all the terms of this plan, the Day Care Expense Benefit is equal to the lesser of: (i) \$10,000 annually; or (ii) the actual annual day care expenses for all of your qualified dependents.

We pay this benefit quarterly, in arrears, upon receipt of proof of qualified day care expenses. Proof should be submitted within 30 days following the end of each calendar year quarter.

Payment will be made to the person who has primary responsibility for these expenses.

**Alternative Minimum Benefit** If you suffer a specified loss but all the requirements for the day care expense benefit are not met, we will pay a one time flat benefit of \$1,000 to you if you are living. If not, we pay the beneficiary named on your enrollment form. If there is no beneficiary when you die, we'll pay the benefit to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters. We completely discharge our liability for payment of the day care expense benefit with payment of the alternative minimum benefit.

**Continued Eligibility For The Day Care Expense Benefit** We require periodic proof that a qualified dependent remains enrolled in a qualified day care program. We require periodic proof of the qualified dependent's day care expenses.

**When The Day Care Expense Benefit Ends** This plan's Day Care Expense Benefits end on the earliest of the following dates:

- (a) the date the dependent is no longer qualified, as defined above;
- (b) the date the dependent is no longer enrolled in a qualified day care program;

## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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- (c) the date we do not receive proof of qualified day care expenses, as required by this plan; and
- (d) four years from the date the first day care expense benefit is paid.

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### DEPENDENT CHILD EDUCATION BENEFIT

If you suffer a specified loss due to an accidental bodily injury, we will pay an education benefit on behalf of a qualified dependent, subject to all the terms below.

#### When And How The Dependent Child Education Benefit Begins

We will pay a Dependent Child Education Benefit when all of the following conditions are met:

- (a) A benefit is payable under this plan's Employee Voluntary Accidental Death and Dismemberment with Catastrophic Loss Benefit (ADDCL), due to a specified loss;
- (b) We receive proof of a qualified dependent's enrollment in an institute of higher learning. The dependent must be a full-time student, as defined by the institute.

**Specified Loss** means: (1) death; (2) a comatose state which lasts for a period in excess of one month; (3) spinal cord injury which results in: (a) quadriplegia; (b) paraplegia; or (c) hemiplegia; or (4) severe head injury which results in loss of cognitive function. Loss of cognitive function means a significant decline or loss in intellectual aptitude. It must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

**Qualified Dependent:** To be qualified for the Dependent Child Education Benefit, a dependent must meet the following conditions. The dependent must be: (a) your: (i) biological child; (ii) lawfully adopted child; (iii) stepchild; or (iv) any other child who is living with you in a regular parent-child relationship; (b) unmarried; and (c) dependent upon you for main support and maintenance. On the date of the accidental injury which results in the specified loss, the dependent must be: (a) 22 years of age or younger; and (b) enrolled as a full-time student in an institute of higher learning; or (c) in the 12th grade, and enroll as a full-time student in an institute of higher learning within 12 months of this date. The dependent must maintain a grade point average of at least 2.0 on a 4.0 scale, or the equivalent.

**Institute of Higher Learning** includes, but is not limited to: (a) universities; (b) colleges; (c) trade schools; and (d) professional schools. It does not include graduate level programs.

#### What We Pay

Subject to all the terms of this plan, the Dependent Child Education Benefit per academic term is equal to the lesser of: (i) the qualified dependent's net tuition expense for the term; (ii) 5% of the Voluntary ADDCL Benefit paid as a result of the specified loss; or (iii) \$2,500.00.

## Your Voluntary Accidental Death And Dismemberment With Catastrophic Loss Benefits (Cont.)

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**Tuition Expense** means charges incurred for credit courses or lab fees. It does not include: (a) cost of books; (b) other related course materials; (c) student activity fees; or (d) room and board.

**Net Tuition Expense** means tuition expense less any scholarships or grants to which the dependent is entitled.

We pay this benefit per academic term for each qualified dependent.

We pay this benefit to the person who has primary responsibility for these expenses.

**Alternative Minimum Benefit** If you suffer a specified loss but all the requirements for the dependent child education benefit are not met, we will pay a one time flat benefit of \$2,000 to you if you are living. If not, we pay the beneficiary named on your enrollment form. If there is no beneficiary when you die, we'll pay the benefit to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters. We completely discharge our liability for payment of the dependent child education benefit with payment of the alternative minimum benefit.

**Continued Eligibility For Dependent Education Benefit** We require periodic proof that a dependent remains a qualified dependent, as defined above. We also require proof, per academic term, of: (a) the qualified dependent's tuition expenses; and (b) any scholarships and grants the dependent is entitled to.

**When The Dependent Child Education Benefit Ends** A qualified dependent's Dependent Child Education Benefit ends on the earliest of the following dates:

- (a) the date the dependent child is no longer a qualified dependent, as defined above;
- (b) the date the dependent fails to furnish proof as required above;
- (c) the date the lifetime maximum benefit amount, shown in the schedule, is reached;
- (d) the date the maximum number of benefit payments, shown in the schedule, is reached; and
- (e) the date the maximum benefit period, shown in the schedule, is reached.

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## ELIGIBILITY FOR DISABILITY COVERAGE

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### Employee Coverage

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**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*.

Your eligibility for Disability coverage under this plan is contingent upon your eligibility for Life and AD&D coverage under this plan.

If you elect Life and AD&D coverage under this plan, you must elect Disability coverage under this plan. If you are not insured for Life and AD&D coverage under this plan, you are not eligible for Disability coverage under this plan.

**Other Conditions** You must:

- (a) be legally working in the United States.
- (b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 20 hours per week), at:
  - (i) your *employer's* place of business;
  - (ii) some place where your *employer's* business requires you to travel; or
  - (iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan*, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved by us in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. Other parts of this coverage explain if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

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**When Your Coverage Starts** Subject to all of this plan's conditions of eligibility set for below; your Long Term Disability coverage under this plan starts on the later of: (a) the effective date of this plan; and (b) the date you become insured for Life and AD&D coverage under this plan.

Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

## Employee Coverage (Cont.)

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Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

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### **Delayed Effective Date For Disability Coverage**

With respect to this *plan's* disability insurance, if an *employee* is not actively at work on a *full-time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury*, we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

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### **When Your Coverage Ends**

Your Disability coverage ends on the date your active service ends for any reason.

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.

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning issued by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

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.

## Employee Coverage (Cont.)

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However, if you are disabled, as defined by this *plan* when your active service ends, coverage remains in force during: (a) the elimination period, subject to premium payment, if (i) the disability is not excluded under the *plan*; and (ii) benefits are not excluded due to application of this *plan*'s pre-existing condition provision; and (b) the period for which benefits are payable under this *plan*.

Your Disability coverage ends on the date you are no longer eligible for Life and AD&D coverage under this plan.

Read this booklet carefully if your coverage ends. You may have the right to replace certain group benefits with converted policies.

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## LONG TERM DISABILITY HIGHLIGHTS

This page provides a quick guide to some of the plan features about which people most often want to know. But it's not a complete description of your long term disability plan. Read the following pages carefully for a complete explanation of what we pay, limit, and exclude.

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### Plan A

**Own Occupation Period** The first 24 months of benefit payments from this plan.

CGP-3-LTD2K-HL

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**Elimination Period** For disability due to injury . . . . . 30 days  
 For disability due to sickness . . . . . 90 days

CGP-3-LTD2K-HL

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**Maximum Payment Period** See the following table:

Age when disability starts	Maximum payment period
Under age 60 . . . . .	To age 65
Age 60 . . . . .	5.00 years
Age 61 . . . . .	4.00 years
Age 62 . . . . .	3.50 years
Age 63 . . . . .	3.00 years
Age 64 . . . . .	2.50 years
Age 65 . . . . .	2.00 years
Age 66 . . . . .	1.75 years
Age 67 . . . . .	1.50 years
Age 68 . . . . .	1.25 years
Age 69 or older . . . . .	1.00 year

CGP-3-LTD2K-HL

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**Benefit Percent** . . . . . 66 2/3%

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**Maximum Monthly Benefit** . . . . . \$1,500.00

CGP-3-LTD2K-HL

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## INTERMEDIATE ABILITYGUARD DISABILITY INCOME INSURANCE

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This insurance replaces part of your income if you become disabled due to sickness or injury.

We decide: (a) if you are eligible for this insurance; (b) if you meet the requirements for benefits to be paid; and (c) what benefits are to be paid by this plan. We also interpret how this plan is to be administered. What we pay and the terms for payment are explained below.

All terms in *italics* are defined terms with special meanings. Their definitions are shown at the end of this section. Other terms are defined where they are used.

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### Claim Provisions

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- Your Duties** If you become *disabled* due to *sickness* or *injury* while insured by this *plan*, you must:
- (a) Give notice of claim as soon as possible after the date of your *injury* or the start of your *sickness*. Prompt notice will permit us to start case management. See the "Rehabilitation and Case Management" section of this *plan* for details.
  - (b) Give a complete account of the details of your *sickness* or *injury*. This will include: (i) the cause of your *disability*, if known; (ii) a description of your *sickness* or the accident that caused your *injury*; and (iii) a list of all *doctors*, hospitals, or other facilities where you have been treated for the cause of your *disability*.
  - (c) Allow release of medical and/or income data needed to assess your claim.
  - (d) Give periodic medical updates as required by this *plan*.
  - (e) Take part in any medical, financial or vocational assessment as required by this *plan*.
  - (f) Apply for other income benefits to which you may be entitled.
  - (g) Promptly report to us the receipt or denial of such other income benefits. And, appeal any denials to the extent possible.
  - (h) Promptly report to us changes in your personal status. This includes: (i) change of address or phone number; (ii) changes in how your *disability* affects your daily living; and (iii) changes in your level of social, volunteer or business activities.
  - (i) If we overpay benefits, promptly report and repay any amount overpaid.
  - (j) If you are working while *disabled*, promptly report to us the amount of your income from such work.
  - (k) Give us proof of your earnings for the period prior to your *disability* and while you are *disabled*.

**Notice** You must send us written notice of your intent to file a claim under this *plan* as described in this certificate's "Accident and Health Claims Provisions." Notice must include:

## Claim Provisions (Cont.)

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- (a) your full name; phone number; social security number, and group number;
- (b) the date of your last day worked; the number of hours you worked; and your job title;
- (c) your *employer* contact and phone number;
- (d) a statement of the nature of your *disability*; and whether or not it is work-related;
- (e) your *doctor's* name, address and phone number.

For details, you can call Guardian at 1-800-538-4583.

**Proof Of Loss** When we receive your notice, we will provide you with a claim form for filing proof of loss. This form requires data from you, the *plan sponsor*, and the *doctor(s)* treating you for your *sickness* or *injury*. Proof of loss must be given to us within the time stated in this certificate's "Accident and Health Claims Provisions." If you do not receive a claim form within 15 days of the date you sent your notice, you should send us written proof of loss without waiting for the form.

We require the items listed below as proof of loss:

- (a) During the *elimination period* and the *own occupation period*, proof of the limits on your ability to perform your *own occupation*, starting on the date you first became *disabled*. This proof is required from all *doctors* who have treated you for the cause of your *disability*.  
  
After the *own occupation* period, proof of your *disability* by an independent entity that specializes in the assessment of a person's: (i) ability to perform *activities of daily living*; and (ii) *cognitive impairment*.
- (b) Proof that you have applied for all other sources of income to which you may be entitled, that may affect your payment from this *plan*.
- (c) Proof of receipt of other income that may affect your payment from this *plan*.
- (d) Your signed authorization for release of medical and/or financial data by the sources of such data.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America  
Group Long Term Disability Claims Department  
P.O. Box 26025  
Lehigh Valley, PA 18002-6025

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## To Qualify For Payments

**How Payments Start** To start getting payments from this *plan*, you must meet all of the conditions listed below:

## To Qualify For Payments (Cont.)

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- (a) You must: (i) become *disabled* while insured by this *plan*; and (ii) remain *disabled* for this *plan's* *elimination period*.
- (b) You must be: (i) under a *doctor's regular care* for the cause of your *disability*, starting from the date you were first *disabled*; and (ii) receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*.
- (c) You must send us written proof of: (i) your *disability*; (ii) your monthly earnings prior to the start of your *disability*; and (iii) any earnings from work while you are *disabled*.

Proof of earnings may consist of: (1) copies of your U.S. Individual Income Tax Returns; (2) a statement from a certified public accountant; or (3) any other records we agree to accept.

**Waiver Of Premium** Premiums for this insurance are waived while you are entitled to receive a payment from this *plan*.

**To Continue Receiving Payments** To continue to receive payments from this *plan*, you must give us current proof of loss when we request it.

You must give proof that satisfies us as to the items listed below:

- (a) your continued *disability*;
- (b) continued *regular care* by a *doctor* that is appropriate for the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*;
- (c) earnings from work while you are *disabled*; and
- (d) any other income that you are entitled to receive.

You must permit periodic assessments of your *disability* by an independent entity that specializes in assessments of a person's: (a) ability to perform *activities of daily living*; or (b) *cognitive impairment*.

You must also give us current signed authorizations for release of medical and financial data when we request it.

You must permit such assessments and give us such items within 90 days of the date we make each such request. If you do not, we have the right to suspend or stop your payments under this *plan*.

**Right To Request Medical, Financial Or Vocational Assessment** We may ask you to take part in a medical, financial or vocational assessment as often as we feel is reasonably necessary. We will pay for all such assessments. If you do not take part in the assessment, without good cause, we have the right to stop or suspend your payments under this *plan*.

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**Payment Of Benefits** We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

## To Qualify For Payments (Cont.)

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We pay benefits once each month at the end of the period for which they are payable.

Benefits to which you are entitled may remain unpaid at your death. Such benefits may be paid at our discretion to: (a) your estate; or (b) your spouse, parents, children, or brothers and sisters.

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## When Benefits End

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**When Payments End** Your benefits from this *plan* will end on the earliest of the dates shown below:

- (a) The date you are no longer *disabled*.
- (b) The date you earn, or are able to earn, the maximum earnings allowed while *disabled* under this *plan*.
- (c) The date you are able to perform the major duties of your *own occupation* on a full-time basis with reasonable accommodation that an employer is willing to provide.
- (d) The date you no longer reside in the United States.
- (e) The date you die.
- (f) The end of the *maximum payment period*.
- (g) The date you fail to give us required current proof of loss. This includes taking part in any medical, financial or vocational assessment we may require.
- (h) The date you are no longer under the *regular care* of a *doctor*.
- (i) The date payments end in accord with a *rehabilitation agreement*.

The term "reasonable accommodation" means any modification or adjustment to: (i) a job; (ii) an employment practice; (iii) a work process; or (iv) the work place. The modification or adjustment must make it possible for a *disabled* person to: (1) reach the same level of performance as a similarly situated non-disabled person; or (2) enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person. The modification or adjustment must not place an undue hardship on the employer.

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## When Benefits End (Cont.)

### Plan ID A

**Maximum Payment Period** The *maximum payment period* is the longest time that benefits are paid by this *plan* for your *disability*. It is determined by the table shown below.

But, it may be less than that shown due to the nature of your *disability*. See "Special Limitations."

Age when disability starts	Maximum payment period
Under age 60	To age 65
Age 60	5.00 years
Age 61	4.00 years
Age 62	3.50 years
Age 63	3.00 years
Age 64	2.50 years
Age 65	2.00 years
Age 66	1.75 years
Age 67	1.50 years
Age 68	1.25 years
Age 69 or older	1.00 year

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## To Determine Your Benefit

### Plan A

Your benefit is determined by the plan of benefits and your *insured earnings* in effect on the date your *disability* starts.

Any changes to this *plan* that take place while you are *disabled* will not affect how we determine your benefit. This is also true for any changes that take place during a period of *active work* that occurs between an initial period of *disability* and a *recurring disability*.

**Determining Your Monthly Benefit** Your *monthly benefit* is determined as shown below.

- Multiply your *insured earnings* by 66 2/3%. Round this amount to the nearest dollar.
- If the amount determined above is less than this *plan's maximum monthly benefit*, that amount is your *gross monthly benefit*.

If the amount determined above is equal to or more than this *plan's maximum monthly benefit*, your *gross monthly benefit* is equal to the *maximum monthly benefit*.

## To Determine Your Benefit (Cont.)

- (c) From your *gross monthly benefit*, subtract the amount of any income with which we integrate that you:
- (i) receive from: disability benefits from any mandated benefit act or law; *retirement benefits* or *retirement plan disability benefits* from any *government plan* due to your *disability*; and benefits from a Workers' Compensation law, an occupational disease law, or any act or law of like intent; and
  - (ii) receive or are entitled to receive from any other income listed in "Income We Integrate With."

The result is your *monthly benefit*.

The amount of your *gross monthly benefit* may be limited if:

- (a) you have not provided any proof of insurability required by this *plan*;
- (b) we have not given you written approval of such proof; or
- (c) the *plan sponsor* has not updated the amount of your *insured earnings* to reflect your then current *insured earnings* on the most recent reporting date prior to the start of your *disability*.

See the "Redetermination" and "Proof of Insurability" section of this *plan* for details.

CGP-3-LTD2K-4.0-NY

B380.1954-R

**Redetermination** Subject to any proof of insurability requirements of this *plan*, as of each January 1st, we use your then current *insured earnings* to set rates and to project benefit amounts and limits under this *plan*. However, you must be *actively-at-work* on a full-time basis on that date. If you are not, we do not do this until the date you return to *active work* on a full-time basis. But, changes in earnings will not apply to a *recurring disability*.

CGP-3-LTD2K-4.2

B380.0057-R

**Income We Integrate With** You may receive, or be entitled to receive, income shown in the list below. We will integrate your *gross monthly benefit* with such income to determine your *monthly benefit* from this *plan*.

- Commissions received, due to be received, or paid after *disability* benefits start. This includes vested and nonvested renewal commissions.
- Disability benefits from any mandated benefit act or law. This includes all temporary disability or state disability benefits required by law.
- Disability benefits from all group plans of: (1) the *plan sponsor*; or (2) your *employer*. This includes payments made by a group life insurance plan due to your *disability*. This does not include payments made from a group life insurance plan's: (a) accelerated death benefit; or (b) like provision that allows payment of such plan's proceeds due to terminal illness.
- Disability benefits from any other group plan.

## To Determine Your Benefit (Cont.)

- Income from a sick leave or salary continuance plan. This applies whether such plan is sponsored on a formal or informal basis. This includes lump sum or recurrent payments of accrued sick leave benefits.
- Benefits as shown below from: (1) the United States Social Security Act; (2) the Railroad Retirement Act; or (3) any other like U.S. or Canadian plan or act.
  - (a) All disability benefits which: (i) you receive; and (ii) your spouse and children receive due to your *disability*;
  - (b) All unreduced retirement benefits which: (i) you receive; and (ii) your spouse and children receive due to your receipt of such benefits; and
  - (c) all reduced retirement benefits paid to: (i) you; and (ii) your spouse and children due to your receipt of such benefits.

We will integrate your *gross monthly benefit* with such benefits to which your spouse and children are entitled due to your *disability*. We do this without regard to: (a) your marital status; (b) where you live; (c) where your spouse lives; (d) where your child lives; or (e) any custody arrangements made on behalf of your child.

- *Retirement plan retirement benefits* funded for your benefit by: (1) the *plan sponsor*; or (2) your *employer*.
- *Retirement plan disability benefits*.
- *Retirement benefits* or *retirement plan disability benefits*, due to your *disability*, from any *government plan* other than those shown above.
- Disability benefits from any: (1) *no-fault motor vehicle coverage*; (2) *motor vehicle financial responsibility act*; or (3) like law.
- Benefits from: (1) a *Workers' Compensation law*; (2) an *occupational disease law*; or (3) any other act or law of like intent. This includes: (a) the *Jones' Act*; (b) the *Longshoreman's and Harbor Workers' Compensation Act*; or (c) any *Maritime doctrine of Maintenance, Wages or Cure*.
- Payment from your *employer* as part of a termination agreement.

Our right to reduce your benefit by such income shall not be negated by a transfer of claim liability to a third party. Payment by such third party by law, settlement, judgement, waiver or otherwise shall not negate our right.

CGP-3-LTD2K-4.3-NY

B380.0703-R

### **Lump Sum Payments Of Other Income**

Income with which we integrate may be paid in a lump sum. In this case, we take the equivalent monthly rate stated in the award into account when we determine your *monthly benefit*. If no monthly rate is given, we pro-rate the lump sum over the lesser of: (a) 60 months; or (b) the *maximum payment period*.

### **Cost Of Living Freeze**

You may receive a cost of living increase in other income with which we integrate. In this case, we do not further reduce your *monthly benefit* by the amount of such increase.

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## To Determine Your Benefit (Cont.)

**Application For Other Income** You must apply for other income benefits to which you may be entitled. If these benefits are denied, you must appeal until: (a) all possible appeals have been made; or (b) we notify you that no further appeals are required.

If we feel you are entitled to receive such income benefits, we will estimate the amount due to you and your spouse and children. We will take this estimated amount into account when we determine your *monthly benefit*. But, we will not take this estimated amount into account if you sign our reimbursement agreement. In this agreement you promise: (a) to apply for any benefits for which you may be eligible; (b) to appeal any denial of such benefits until all possible appeals have been made; and (c) to repay any amount we overpaid due to an award of such benefits. This paragraph does not apply to: (i) disability benefits from any mandated benefit act or law; (ii) *retirement benefits* or *retirement plan disability benefits* from any *government plan* due to your *disability*; and (iii) benefits from a Workers' Compensation law, an occupational disease law, or any other act or law of like intent.

If we do reduce your *gross monthly benefit* by an estimated amount, we will adjust your *monthly benefit* when we receive written proof: (a) of the amount awarded; or (b) that the other income benefits have been denied; and no further appeals are possible. If we underpaid you, we pay the full amount of the underpayment in a lump sum.

We will assist you in applying for other income benefits.

CGP-3-LTD2K-4.4-NY

B380.0706-R

**Minimum Payment** The minimum monthly payment for *disability* under this *plan* is \$50.00.

**Partial Month Payment** You may be *disabled* for only part of a month. In this case, we compute your payment as 1/30th of the benefit to which you would be entitled for the full month times the number of days you are *disabled*. Payment will not be made for more than 30 days in any month.

**Overpayment Recovery** If we overpaid you, you must repay us in full. We have the right to reduce your payment or apply any benefits payable, including the minimum payment, toward recovery of the overpayment.

CGP-3-LTD2K-4.5

B380.0064-R

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## If You Work While Disabled

**Income Earned During Disability** Subject to the other terms of this *plan*, *income earned during disability* is treated as shown below. In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

1. For each of the first 12 months after you return to work, add your *gross monthly benefit* and your *income earned during disability*.
  - (a) If the sum is not more than 100% of your *insured earnings*, we do not reduce your *monthly benefit* for that month.
  - (b) If the sum is more than 100% of your *insured earnings*, we reduce your *monthly benefit* for that month by the amount over 100% of your *insured earnings*.

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## If You Work While Disabled (Cont.)

2. For each month after 12 months of work while *disabled*:
  - (a) If your *income earned during disability* is less than 20% of your *insured earnings*, we do not reduce your *monthly benefit* for that month.
  - (b) If your *income earned during disability* is 20% or more of your *insured earnings*, we reduce your *monthly benefit* for that month by 50% of your *income earned during disability*.

CGP-3-LTD2K-5.0

B380.3302-R

### Maximum Income Earned During Disability

This *plan* limits the amount of income you may earn, or may be able to earn, and still be considered *disabled*.

If your *income earned during disability* is more than 80% of your *insured earnings*, payments from this *plan* will end. Payments from this *plan* will also end if you are able to earn more than 80% of your *insured earnings*.

In all cases, your *insured earnings* are adjusted each year by an indexing factor. See the "Indexing" section of this *plan* for how this is done.

CGP-3-LTD2K-5.1

B380.0071-R

### Indexing

If you return to work while *disabled*, we adjust your *insured earnings* each year. We do this by means of an indexing factor. This factor increases the amount of income you may earn and still be considered *disabled*. This adjustment does not increase your *gross monthly benefit*, *monthly benefit*, or any other benefit under this *plan*.

We make the first indexing adjustment after you: (a) have returned to work; and (b) have received 12 monthly payments in a row from this *plan*.

To make the first adjustment, we multiply your *insured earnings* by the indexing factor for that year. To make adjustments in each later year, we multiply the amount of your last indexed *insured earnings* by the indexing factor for the current year.

The indexing factor is the lesser of: (a) 10%; or (b) one-half of the percentage change in the *CPI-W* for the prior calendar year.

CGP-3-LTD2K-5.2

B380.0073-R

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## Recurring Disability

Your benefits from this *plan* will end because you cease to be *disabled*. In this case, a later *disability* may be treated as a *recurring disability*. The terms listed below must be met:

- (a) You return to *active work* right after your benefits end;
- (b) Your *disability* recurs less than six months after you were last entitled to benefits;
- (c) Your later *disability* is due to the same cause of, or a cause related to the cause of, your earlier *disability*;
- (d) This *plan* does not end during your return to *active work*;

## Recurring Disability (Cont.)

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- (e) You do not become covered under any other similar group income replacement plan during the time you return to *active work*; and
- (f) During the time you return to *active work*, you stay insured by this *plan* and premium payments are made on your behalf.
- (g) Your benefits do not end because you have used up the *maximum payment period*.

Any changes in benefit or the *plan* which take place during your return to *active work*, will not apply to the *recurring disability*.

If the later *disability* is a *recurring disability*, you will not need to complete a new *elimination period* before becoming entitled to benefits. Your claim for *recurring disability* will be subject to the same terms of the *plan* as your earlier *disability*.

CGP-3-LTD2K-6.0

B380.0075-R

## Services Available

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**Social Security Assistance** We may feel you are qualified for Social Security disability benefits. If so, we may offer to help you apply for them. If such benefits are under review by Social Security, we may also offer to help you keep them.

We may offer to help:

- (a) Fill out your application for such benefits, and any related forms;
- (b) Find suitable legal counsel; and
- (c) Give medical and vocational data needed to file your claim.

You must apply for all income benefits for which you may be eligible, whether or not you use our help. Using our help does not cancel your duties shown in the "Application for Other Income" section of this *plan*.

### Rehabilitation And Case Management

Case management starts when we are notified of your *disability*.

We will review your *disability* to see if certain services are likely to help you return to *gainful work*. If needed, we may ask for more medical or vocational information.

When our review is complete, we may offer you a *rehabilitation program*.

The *rehabilitation program* will start when a written *rehabilitation agreement* is signed by: (1) you; (2) us; and (3) your *employer*, if needed. The program may include, but is not limited to:

- (a) vocational assessment of your work potential;
- (b) coordination and transition planning with an employer for your return to work;
- (c) consulting with your *doctor* on your return to work and need for accommodations;
- (d) training in job seeking skills and resume preparation;

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## Services Available (Cont.)

- (e) retraining;
- (f) child care expense aid; and
- (g) aid in worksite alteration made to comply with the Americans with Disabilities Act. This includes a one-time payment of up to \$500.00.

We have the right to determine which services are appropriate.

If you accept the *rehabilitation agreement*, we will pay an enhanced benefit. The enhanced benefit will be 110% of the *monthly benefit* that would otherwise be paid. This enhanced benefit will be payable as of the first *monthly benefit* after the *rehabilitation program* starts.

We stop paying the enhanced benefit on the earliest of:

- (a) The date your benefits from this *plan* end,
- (b) The date you violate the terms of the *rehabilitation agreement*;
- (c) The date you end the *rehabilitation program*; and
- (d) The date the *rehabilitation agreement* ends.

If you end a *rehabilitation program* without our consent, you must repay any enhanced benefits paid.

CGP-3-LTD2K-8.0-NY

B380.0711-R

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## Pre-Existing Conditions

**Pre-Existing Conditions** A pre-existing condition is a *sickness* or *injury*, including all related conditions and complications, for which, in the look back period, you:

- (a) receive advice or treatment from a *doctor*;
- (b) take prescribed drugs; or
- (c) receive other medical care or treatment, including consultation with a *doctor*.

You may have been prescribed drugs by a *doctor* for a condition to be taken during the look back period. In that case, such condition or a related condition will be considered pre-existing.

The "look back period" is the twelve months before the latest of: (a) the effective date of your insurance under this *plan*; (b) the effective date of a change that increases the benefits payable by this *plan*; and (c) the effective date of a change in your benefit election that increases the benefit payable by this *plan*.

A pregnancy that exists on the date your insurance under this *plan* starts is also a pre-existing condition.

No benefits are payable for *disability* due to a pre-existing condition, unless the *disability* starts after you complete at least one full day of *active work* after the date you are insured under this *plan* for 12 months in a row.

## Pre-Existing Conditions (Cont.)

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You may become *disabled* due to a pre-existing condition after: (a) a change which provides for an increase in the benefits payable by this *plan*; or (b) a change in your benefit election which increases the benefit payable by this *plan*. In this case, your benefit will be limited to the amount that would have been payable had the change not taken place. This limit does not apply if your *disability* starts after you complete at least one full day of *active work* after the change has been in force for 12 months in a row.

We do not cover any *disability* that starts before your insurance under this *plan*.

CGP-3-LTD2K-9.0

B380.0090-R

**Prior Coverage Credit** If this *plan* replaces a similar income replacement plan the *plan sponsor* had with another insurer, the pre-existing condition provision may not apply to you. This *plan* must start within 60 days the old plan ends.

We credit any time used to meet the old plan's pre-existing condition provision toward meeting this *plan's* pre-existing condition provision. If the old plan did not have a pre-existing condition provision, we credit any time you were covered under the old plan toward meeting this *plan's* pre-existing condition provision. We do this if: (a) you were covered under the old plan when it ended; and (b) you are *actively-at-work* and enroll for insurance on the effective date of this *plan*.

But, we limit the *maximum monthly benefit* under this *plan* if: (a) it is more than the old plan's maximum; (b) you become *disabled* due to a pre-existing condition; and (c) this *plan* pays benefits for such *disability* because we credit time as explained above. In this case, we limit the *maximum monthly benefit* to an amount equal to the old plan's maximum until the day after the date you are insured under this *plan* for 12 months in a row.

We deduct all payments made by the old plan under an extension provision.

Also, you may have been covered under a group or blanket disability insurance plan or policy or an employer-provided disability plan prior to your enrollment in this *plan*. When this happens, we may credit any time you were covered under the prior plan toward meeting this *plan's* pre-existing condition provision. To determine if a condition is pre-existing, we go back to the date your coverage under the prior plan started. We do this if: (a) the prior plan was substantially similar to this *plan*; (b) your active full-time service with the *employer* starts within 60 days of the date your coverage under the prior plan ended; and (c) you enroll in this *plan* within such 60 day period, or if later, within 31 days of the date you first become eligible under this *plan* during such 60 day period. If the *plan sponsor* has included an eligibility waiting period in the *plan*, you must still meet it before becoming insured under this *plan*.

CGP-3-LTD2K-9.1-NY

B380.0713-R

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## Not Covered

**Exclusions** This *plan* does not pay benefits for *disability* caused by, or related to:

- (a) declared or undeclared war, act of war, or armed aggression;

- (b) service in the armed forces, National Guard, or military reserves of any state or country;
- (c) your taking part in a riot or civil disorder;
- (d) your commission of, or attempt to commit a felony;
- (e) your being engaged in an illegal occupation; or
- (f) intentional self-inflicted injuries.

We do not pay any benefits for any period of *disability*:

- (1) during which you are not receiving *regular care* by a *doctor*;
- (2) during which you are not receiving medical care appropriate to the cause of your *disability* and any other *sickness* or *injury* which exists during your *disability*;
- (3) which starts before you are insured by this *plan*; or
- (4) during which your loss of earnings is not solely due to your *disability*.

CGP-3-LTD2K-10.0-NY

B380.0714-R

### **Converting This Group Intermediate AbilityGuard Disability Income Insurance**

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**If Employment Ends** When your coverage under this group Intermediate AbilityGuard Disability income insurance *plan* ends, you may apply for converted disability income coverage.

You may apply for this converted coverage if you: (a) are not *disabled* as defined by this *plan*; and (b) have been covered under this *plan* for at least 12 months in a row. To meet this 12 months requirement, we will include any time you were covered under a similar group disability income replacement plan which this *plan* replaced.

But, you will not be eligible for the converted coverage if your coverage under this *plan* ends because: (a) you: (i) fail to make a required contribution; (ii) change to a class not eligible under this *plan*; or (iii) retire; (b) this *plan* ends; or (c) this *plan* is amended to end coverage for all persons in a class.

**How And When To Convert** You must apply to us in writing and pay any required premium for the converted coverage. You must do this within 31 days of the date your coverage under this *plan* ends.

We won't ask for proof of good health. But, issuance of the converted coverage may be subject to other underwriting criteria. You must give us details about all other disability income insurance that: (a) you have; or (b) for which you have applied; or (c) for which you may become eligible under another plan within 31 days after your coverage under this *plan* ends.

Guardian will not issue the converted coverage if such coverage would result in your being overinsured by our standards.

## Converting This Group Intermediate AbilityGuard Disability Income Insurance (Cont.)

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**The Converted Coverage** Your converted coverage, if issued, will be effective on the date your coverage under this *plan* ends. The benefits, terms and conditions of the converted coverage will be those in use in the state where you then live. These may be different from the benefits, terms and conditions of this *plan*.

The premium for the converted coverage will be that in effect for your age and class of risk on the date the converted coverage is issued.

CGP-3-LTD2K-11.0

B380.0096-R

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### Definitions

**Active Work, Actively-At-Work Or Actively Working** You are able to perform and are performing all of the regular duties of your work for your *employer*, on a full-time basis at: (a) one of your *employer's* usual places of business; (b) some place where your *employer's* business requires you to travel; or (c) any other place you and your *employer* have agreed on for your work.

CGP-3-LTD2K-12.0

B380.0098-R

- Activities Of Daily Living**
- (1) **Bathing:** the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry; with or without equipment or adaptive devices.
  - (2) **Dressing:** the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.
  - (3) **Toileting:** the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.
  - (4) **Transferring:** the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.
  - (5) **Continence:** the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.
  - (6) **Eating:** the ability to get food into the body by any means once it has been prepared and made available.

**Cognitive Impairment Or Cognitively Impaired** A decline or loss in intellectual aptitude. Such loss may result from: (a) *injury*; (b) *sickness*; (c) Alzheimer's disease, or (d) like forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

CGP-3-LTD2K-12.1

B380.0099-R

## Definitions (Cont.)

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**CPI-W** That part of the United States Department of Labor Consumer Price Index that measures the relative value of the cost of a typical urban wage earner's purchase of certain goods and services. The change in cost is expressed as a percentage of the cost of those goods and services in a base period. When we compute the change in *CPI-W*, we use the value of the *CPI-W* published in December of that year and the value published in December of the prior year. If the Department of Labor stops publishing the *CPI-W*, we have the right to use some other similar standard.

CGP-3-LTD2K-12.2

B380.0100-R

**Disability Or Disabled** These terms mean you have physical, mental or emotional limits caused by a current *sickness* or *injury*. And, these limits cause you to meet the conditions shown below:

- (1) During the *elimination period* and the *own occupation* period, you are not able to perform, on a full-time basis, the major duties of your *own occupation*.
- (2) After the end of the *own occupation* period, you are: (a) not able to perform two or more *activities of daily living*, on a routine basis, without help; or (b) *cognitively impaired* and need verbal cueing to protect yourself or others.

You are not *disabled* if you earn, or are able to earn, more than this *plan's* maximum allowed *income earned during disability*.

You may be required, on average, to work more than 40 hours per week. In this case, you are not *disabled* if you are able to work for 40 hours per week.

Loss of a professional or occupational license will not, in itself, constitute *disability*.

CGP-3-LTD2K-12.5

B380.0106-R

**Doctor** Any medical practitioner we are required by law to recognize. He or she must: (a) be properly licensed or certified by the laws of the state where he or she practices; and (b) provide services that are within the lawful scope of his or her practice. We do not recognize you, or your spouse, child, parent, sibling, or business associate, as a *doctor* with respect to your claim for this *plan's* benefits.

**Elimination Period** The period of time you must be *disabled*, due to a covered *disability*, before this *plan's* benefits are payable.

Any days during which you return to *active work* will not count toward the *elimination period*. The *elimination period* will be extended by one day for each day of *active work*. If you become eligible under any other similar group income replacement plan while you are at *active work*, you will not be entitled to benefits from this *plan*.

**Employer** The business entity that employs you and is: (a) the *plan sponsor*; or (b) associated with the *plan sponsor*.

CGP-3-LTD2K-12.10

B380.0112-R

## Definitions (Cont.)

**Government Plan** Any of the following: (1) the United States Social Security Act; (2) the Railroad Retirement Act; (3) the Canadian Pension Plan; or (4) any other plan provided under the laws of a state, province or any other political subdivision. It also includes: (a) any public employee retirement plan; or (b) any plan provided in place of the above named plan or acts. It does not include: (i) any Workers' Compensation Act or similar law; (ii) the Jones' Act; (iii) the Longshoreman's and Harbor Workers' Compensation Act; or (iv) the Maritime Doctrine of Maintenance, Wages, or Cure.

**Gross Monthly Benefit** This *plan's monthly benefit* before it is integrated with other income and earnings.

**Income Earned During Disability** The monthly income you earn from working while *disabled*. It includes any income you earn while *disabled* but which is returned to your *employer*, partnership, or any other similar business arrangement to cover any business or overhead expenses.

**Injury** A bodily *injury* due to an accident that occurs, independent of all other causes, while you are insured by this *plan*. We will cover a *disability* caused by an *injury* when the *disability* starts within 90 days of the date of such *injury*.

CGP-3-LTD2K-12.11

B380.0113-R

**Insured Earnings** Only your earnings from the *employer* will be included as *insured earnings*.

We calculate benefit amounts and limits based on the amount of your *insured earnings* on record with us as of the Redetermination date immediately prior to the start of your *disability*. See the "Redetermination" section of this *plan*.

*Insured earnings* includes your contributions deposited into a cash or deferred compensation plan, or salary reduction plan, qualified under IRC Section 401(k), 403(b) or 457. Earnings based on excluded income and *employer* contributions deposited into such 401(k), 403(b) or 457 plan are excluded.

For all covered persons, *insured earnings* means your rate of monthly earnings, excluding expense accounts, and any other extra compensation, as reported by the *plan sponsor*. We do not include pay for hours worked or billed over 40 per week. Such earnings are multiplied by 4.333.

Monthly earnings may include:

The average of your bonuses and commissions for the 24 months prior to the most recent redetermination date on which the *plan sponsor* has provided earnings data to us; or, if employed less than that time, the average of your bonuses and commissions for the full time you were employed.

CGP-3-LTD2K01-12.12

B380.2130-R

**Maximum Payment Period** The longest time that benefits are paid by this *plan*.

**Mental Or Emotional Conditions** Include, but are not limited to: (a) neurosis; (b) psychoneurosis; (c) psychosis; (d) psychopathy; and (e) any other mental or emotional disorder, including those caused by chemical imbalance.

## Definitions (Cont.)

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- Monthly Benefit** This *plan's gross monthly benefit* reduced by other income. If you are working while *disabled*, your *monthly benefit* will be further reduced based on the amount of your *income earned during disability*. See the "If You Work While Disabled" provision of this *plan* for how this is done.
- CGP-3-LTD2K-12.13 B380.0129-R
- No-Fault Motor Vehicle Coverage** A motor vehicle plan that pays disability or medical benefits no matter who was at fault in an accident.
- Own Occupation** Your occupation as done in the general labor market in the national economy. To determine the duties and requirements of your *own occupation*, we use: (a) the job description provided by the *plan sponsor*; and (b) the duties and requirements of that occupation as shown in the most recent version of the Dictionary of Occupational Titles. That document is published by the Department of Labor. If the Department stops publishing that document, we have the right to use some other similar standard.
- Plan Sponsor** The employer, association, union, trustee, or other group to which this *plan* is issued.
- Recurring Disability** A later *disability* that: (a) is related to an earlier *disability* for which this *plan* paid benefits; and (b) meets the conditions described in "Recurring Disability."
- Regular Care** You are being treated by, or in consultation with, a *doctor* at a frequency that is consistent with your condition. The requirement for *regular care* does not apply if you have reached your maximum point of recovery yet are still *disabled* under the terms of this *plan*.
- CGP-3-LTD2K-12.14 B380.0133-R
- Rehabilitation Agreement** A formal agreement between; (a) you; (b) us; and (c) your *employer*, if needed. It outlines the *rehabilitation program* in which you agree to take part.
- Rehabilitation Program** A program of work or job-related training for you that we approve in writing. Its aim is to restore your wage earning abilities.
- Retirement Plan** A defined benefit or defined contribution plan funded wholly or in part by the *employer's* deposits for your benefit. The term does not include: (a) profit sharing plans; (b) thrift plans; (c) non-qualified deferred compensation plans; (d) individual retirement accounts; (e) tax sheltered annuities; or (f) stock ownership plans.
- Retirement Plan "retirement benefits"* are lump sum or periodic payments at normal or early retirement. Some *retirement plans* make payments for disability (as defined by those plans) that start before normal retirement age. When such payments reduce the amount that would have been paid at normal retirement age, they are *retirement benefits*. When such payments do not reduce the normal retirement amount, they are "**disability benefits**."
- Sickness** An illness or disease. Pregnancy is treated as a *sickness* under this *plan*.

## Definitions (Cont.)

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**We, Us, And Guardian** The Guardian Life Insurance Company of America.

**You** The person insured by this *plan*.

CGP-3-LTD2K-12.15

B380.0135-R

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## CERTIFICATE AMENDMENT

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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, Group Products

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## REQUIRED DISCLOSURE STATEMENT

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**For Group Plan No.:** G -00369397-

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)

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.

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## GLOSSARY

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This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118-R

**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.

CGP-3-GLOSS-90

B750.0006-R

**Employer** means HEALTHPASS INSURANCE TRUST .

CGP-3-GLOSS-90

B900.0051-R

**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 20 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1

B750.0230-R

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

CGP-3-GLOSS-90

B900.0039-R

**Proof or Proof of Insurability** means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90

B900.0010-R

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## STATEMENT OF ERISA RIGHTS

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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.

### **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.

## Statement of Erisa Rights (Cont.)

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**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.

B800.0093-R

## Disability Benefits Claims Procedure

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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.

**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.

Guardian will provide a benefit determination not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 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 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

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 45 days after receipt of the claim.

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.

## Disability Benefits Claims Procedure (Cont.)

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- 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;
  - references to the specific *plan* provision 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 which a claimant may follow to have a claim for benefits reviewed 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;
  - 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; and
  - 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.

- 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.

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

## Disability Benefits Claims Procedure (Cont.)

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- 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 not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

**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.

B800.0075-R

## Termination of This Group Plan

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

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

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

B800.0007-R

## **Life And Accidental Death And Dismemberment Insurance Claims Procedure**

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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.

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")

- (a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.
- (b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.
- (c) If a claim is denied, Guardian will provide a notice that will set forth:
  - (1) the specific reason(s) the claim was denied;
  - (2) specific references to the pertinent plan provision on which the denial is based;
  - (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
  - (4) an explanation of the plan's claim review procedure. A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.
- (d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

B800.0079-R

## Termination of This Group Plan

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

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

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

B800.0007-R



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## **SECTION II: Managed DentalGuard Expense Plan**

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**This part of your booklet is your Managed DentalGuard dental care expense plan.**

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

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## GENERAL PROVISIONS

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### Definitions

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As used in this certificate of coverage, the terms listed below are defined as follows. These terms are italicized when used in this certificate of coverage. Defined terms are specific to a particular insurance coverage as found within that coverage.

"Employer" means the *employer* who purchased this *plan*.

"Member" means an *employee* or a *dependent* covered by this *plan*.

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

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

"You" and "your" mean an *employee* covered by this *plan*.

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### Limitation of Authority

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No agent is authorized: (a) to alter or amend this *plan*; (b) to waive any conditions or restrictions contained in this *plan*; (c) to extend the time for paying a premium; or (d) to bind The Guardian by making any promise or by giving or receiving any information.

No change in this *plan* shall be valid unless evidenced by: (a) an endorsement or rider to this *plan* signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of The Guardian; or (b) an amendment to this *plan* signed by the *planholder* and by one of the aforesaid officers of The Guardian.

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### Incontestability

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This *plan* will be incontestable after two years from its effective date, except for non-payment of premiums.

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

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

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### Examination

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We have a right to have a doctor or *dentist* of our choice examine the person for whom a claim is being made under this *plan* as often as may be reasonably necessary. We 'll pay for all such examinations.

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## MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

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**Enrollment Procedures** You and your *dependents* may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your *employer*; and (b) returning the materials to your *employer*, who will forward it to Guardian. After that, you and your *dependents* need only contact the selected and assigned *primary care dentist's* office to obtain services.

Guardian will issue you and each of your *dependents*, either directly or through the representative of your *employer*, a Managed DentalGuard (MDG) identification (ID) card, listing the *member's* name and the name, address and telephone number of his or her selected *primary care dentist (PCD)*.

**Open Enrollment Period** If you do not enroll for dental coverage under this *plan* within 30 days of becoming eligible, you must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every twelve (12) months after this *plan* starts, or at a time mutually agreed upon by your *employer* and Guardian.

Your enrollment is for a minimum of twelve (12) consecutive months while you are eligible through your *employer*. Voluntary termination from this *plan* will only be permitted during the open enrollment period.

If, after initial enrollment, you or one of your *dependents* disenroll from the *plan* during an open enrollment period, the *member* may not re-enroll until the open enrollment period which occurs after he or she has been without coverage for one (1) full year.

**When Your Coverage Starts** Your coverage starts on the date shown on the face page of this booklet if you are enrolled when the *plan* starts. If you are not enrolled on that date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by Guardian; or (b) at the end of any waiting period your *employer* may require.

**When Your Dependent Coverage Starts** Except as stated below, your *dependents* will be eligible for coverage on the later of: (a) the day you are eligible for coverage; or (b) the first day of the month following the date on which you acquire such *dependent*.

If the *dependent* is a newborn child, his or her coverage begins on the date of birth. If the *dependent* is: (a) an adopted child; (b) a stepchild; or (c) a foster child, coverage begins on the date the child is placed in your home. If a newborn child, adopted child or foster child becomes covered under this *plan*, you must complete enrollment materials for that *dependent* within 30 days of the date the child is born, adopted or placed for adoption.

**When Coverage Ends** Subject to any continuation of coverage privilege which may be available to you, your *dependents'* coverage under this *plan* ends when your coverage terminates. A *member's* coverage also ends on the first to occur of:

- (1) Upon your failure to pay the required premium in accordance with the provisions of this *plan*, if you are required to pay any part of this *plan*.
- (2) The end of the month in which you or your *dependents* cease to be eligible for coverage under this *plan*.
- (3) The end of the month in which your *dependent* is no longer a *dependent* as defined in this *plan*.

## Member Eligibility and Termination Provisions (Cont.)

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- (4) The date on which *you* or your *dependent* no longer reside or work in the *service area*.
- (5) The end of the 45 day period in which *you* fail to pay any required *patient charge* for services rendered to *you* or your *dependent*, after advance written notice has been sent to *you* of such failure to pay.
- (6) The date *you* or your *dependent* enters active military duty. But, coverage will not end if the *member's* duty is temporary. "Temporary" means duty of 31 days or less.
- (7) Immediately, if *you* or your *dependent*: (a) have knowingly given false information in writing on an enrollment form; or (b) have misused your ID card or other documents provided to obtain benefits under this *plan*.
- (8) 30 days after written notice is sent to *you* advising that *you* or your *dependent's* coverage will end because *we* have determined that: (a) the *member's* behavior is (i) disruptive; (ii) unruly; (iii) abusive; (iv) unlawful; (v) fraudulent; or (vi) uncooperative to the extent that the *member's* continued participation in the *plan* seriously impairs the *plan's* ability to provide services to either your *employer* or to other *members*; or (b) the *member* is not able to maintain an appropriate dentist-patient relationship.

We will have:

- (a) made a reasonable effort to resolve the problem presented by the *member*, including the use or attempted use of *member* grievance procedures;
- (b) ascertained, to the extent possible, that the *member's* behavior is not related to the use of medical services or medical illness; and
- (c) documented the problems, efforts and medical conditions on which the problem is based.

*Member* termination under items (7) and (8) above is subject to the rights of appeal described in the Grievance Process section of the *plan*.

**Extension Of Dental Expense Benefits** If a *member's* coverage ends, we extend dental expense benefits for him or her under this *plan* as explained below.

## Member Eligibility and Termination Provisions (Cont.)

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If a *member's* coverage ends for a reason other than failure to pay any required premium, we only extend benefits for a covered service if the procedure is started before the *member's* coverage ended, subject to all applicable *plan* guidelines. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. Orthodontic treatment is started when the teeth are banded. Root canal is started when the pulp chamber is opened.

This extension of benefits ends on the first to occur of: (a) completion of a procedure which was started before the *member's* coverage ended; (b) 30 days after the *member's* coverage ends; or (c) the date the *member* becomes covered under another plan providing coverage for similar dental procedures.

What we cover is based on all the terms of this *plan*.

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## YOUR CONTINUATION RIGHTS

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*You and your dependents may be eligible to retain coverage under this plan during any Continuation of Coverage period or election period, necessary for your employer's compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for members, provided the employer continues to certify the eligibility of the member and the monthly premiums for COBRA coverage for the member continue to be paid by or through the planholder pursuant to this plan.*

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### An Important Notice About Continuation Rights

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

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### Federal Continuation Rights

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**Important Notice** This section applies to dental benefits only. In this section, these coverages are referred to as "group dental benefits."

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

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.

**If Your Group Dental Benefits End** If your group dental benefits end due to termination of employment or reduction of hours, you may elect to continue such benefits for up to 18 months if: (a) you were not terminated due to gross misconduct; (b) you are not covered for benefits from any other group plan at the time your group dental benefits under this plan would otherwise end; and (c) you are not entitled to Medicare.

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

## Federal Continuation Rights (Cont.)

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- Extra Continuation For Disabled Qualified Continuees** If a qualified continuee is determined to be disabled under Title XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to his or her termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.
- To elect the extra 11 months of continuation, the qualified continuee must give your *employer* written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; and (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your *employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."
- This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends."
- An additional 50% of the total premium charge also may be required from the qualified continuee by your *employer* during this extra 11 month continuation period.
- If You Die While Insured** If *you* die while insured, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."
- If Your Marriage Ends** If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group dental benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends."
- If A Dependent Loses Eligibility** If a *dependent's* group dental benefits end due to his or her loss of *dependent* eligibility as defined in this *plan*, other than your coverage ending, he or she may elect to continue such benefits. However, such *dependent* must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".
- Concurrent Continuations** If a *dependent* elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) reduction of work hours, the *dependent* may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the *dependent* becomes eligible for 36 months of group dental benefits stated above; or (ii) *you* become entitled to Medicare.
- The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.
- The Qualified Continuee's Responsibilities** A person eligible for continuation under this section must notify your *employer*, in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of *dependent* eligibility, as defined in this *plan*, of a *dependent*.
- Such notice must be given to your *employer* within 60 days of either of these events.

## Federal Continuation Rights (Cont.)

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**Your Employer's Responsibilities** Your *employer* must notify the qualified continuee, in writing, of: (a) his or her right to continue this *plan's* group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer*, in writing, of your legal divorce or legal separation from your spouse, or the loss of *dependent* eligibility of a *dependent*.

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

**Election Of Continuation** To continue his or her group dental benefits, the qualified continuee must give your *employer* written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's premium in a timely manner.

The subsequent premiums must be paid to 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 monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed enrolled in the group *plan* on a regular basis. It includes any amount that would have been paid by your *employer*. Except as explained in the "Extra Continuation for Disabled Qualified Continuees" an additional charge of 2% of the total premium charge may also be required by your *employer*.

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

**Grace In Payment of Premiums** A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

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

(a) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental benefits would otherwise end;

## Federal Continuation Rights (Cont.)

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- (b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that the continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (c) with respect to continuation upon the your death, your legal divorce or legal separation, or the end of a *dependent's* eligibility, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
- (d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
- (e) the date the *plan* ends;
- (f) the end of the period for which the last premium payment is made;
- (g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or
- (h) the date he or she becomes entitled to Medicare.

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## DENTAL EXPENSE COVERAGE

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This *plan* will cover many of the dental expenses incurred by you and those of your dependents who are covered for dental benefits under this *plan*. We decide: (a) the requirements for services to be paid; and (b) what benefits are to be paid by this *plan*. We also interpret how this *plan* is to be administered. What we cover and the terms of coverage are explained below. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

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### Managed DentalGuard -This *Plan's* Dental Coverage Organization

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**Managed DentalGuard** This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires members to seek dental care from participating dentists that belong to the MDG network. Except for emergency dental services, in no event will we pay for dental care provided to a member by a non-participating dentist.

The MDG network is made up of participating dentists in a member's geographic area. A "participating dentist" is a *dentist* that has an MDG participation agreement in force with us.

When a member enrolls in this *plan*, he or she will get information about Guardian's current participating general dentists. Each member must select from this list of participating general dentists a primary care *dentist* (PCD) who will be responsible for coordinating all of the member's dental care. After enrollment, a member will receive a MDG ID card. A member must present this ID card when he or she goes to his or her PCD.

All dental services covered by this *plan* must be coordinated by the PCD whom the member selects and is assigned to upon enrolling in this *plan*. What we cover is based on all the terms of this *plan*. Please read this material with care. Read this plan carefully for specific benefit levels, exclusions, coverage limits and patient charges.

You can call our Member Services Department at 1-888-618-2016 if you have any questions after reading this booklet.

**Choice Of Dentists** A member may select any available participating general *dentist* as his or her PCD. A request to change PCDs must be made to us. Any such change will be effective the first day of the month following approval. We may require up to 30 days to process and approve any such request. All fees and patient charges due to the member's current PCD must be paid in full prior to such transfer.

## **Managed DentalGuard -This *Plan's* Dental Coverage Organization (Cont.)**

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We compensate our participating general dentists through an advance payment agreement by which they are paid a fixed amount of money each month based upon the number of members that select them as their PCD. In addition, we may make supplemental payments on a limited number of specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the participating general *dentist* receives from us. The dentists also receive compensation from *plan* members who may pay an office visit charge for each office visit and a defined patient charge for specific dental services. The schedule of patient charges is shown in the Covered Dental Services And Patient Charges section of this booklet.

### **Continuity Of Care For New Members**

If a newly enrolled member is in an ongoing course of treatment with a non-participating dentist; and the member has a life-threatening disease or condition; or the member has a degenerative or disabling condition; and the member elects to continue care from his or her current *dentist*, we will authorize such care for up to 60 days. But, the current *dentist* must agree:

- i) to be reimbursed at contracted rates and payment of any patient charge which may apply, as payment in full;
- ii) to adhere to our quality assurance requirements;
- iii) to provide necessary medical information related to such care; and
- iv) to otherwise adhere to our policies and procedures.

The above policies and procedures include, but are not limited to: (a) pre-authorization of referrals; and (b) offering the member a treatment plan approved by us.

We will not provide benefits for any service or procedure which, subject to applicable plan guidelines; (a) is not a covered service under this *plan*; or (b) is in excess of the limits specified in the "Limitations" section of this booklet.

### **Changes In Dentist Participation**

If: (a) the *dentist* you have selected is no longer a participating *dentist* in the MDG network; or (b) if we take an administrative action which impacts the dentist's participation in the network, we may have to assign you to a different participating *dentist*. In the event that this occurs, you will have the opportunity to choose another participating *dentist* from among those in the MDG network. If you have a dental procedure in progress when reassignment becomes necessary, we will, at your option and subject to applicable law, either: (a) arrange for completion of the services by the original participating *dentist*, if he or she agrees: (i) to accept payment at the contracted rate; and (ii) to abide by all *plan* provisions; or (b) make reasonable and appropriate arrangements for another participating *dentist* to complete the service. We will send you written notice when we are aware that a participating *dentist* is no longer available to treat you. This will be done within fifteen (15) days from the date we become aware that he or she will no longer be available.

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## **Managed DentalGuard - This *Plan's* Dental Coverage Organization (Cont.)**

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**Specialty Referrals** A member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a participating specialist. We will pay for covered services for specialty care, less any applicable patient charges, when such specialty services are provided in accordance with the specialty referral process described below.

We compensate our participating specialists the difference between their contracted fee and the patient charge shown in the Covered Dental Services And Patient Charges section. This is the only form of compensation that participating specialists receive from us.

ALL SPECIALTY REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY GUARDIAN; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty services to be covered by this *plan*, the following referral process must be followed:

- (1) A member's PCD must coordinate all dental care.
- (2) When the care of a participating specialist is required, the member's PCD must contact us and request authorization.
- (3) If the PCD's request for specialist referral is approved, we will notify the member. He or she will be instructed to contact the participating specialist to schedule an appointment.
- (4) If the PCD's request for specialist referral is denied, the PCD and the member will be notified of the reason for the denial. Referrals may be denied because:
  - (a) The service requested is within the scope of the PCD's responsibility. This is called "denial of access to a referral". Please see the "Grievance Process" in this booklet;
  - (b) The service requested is not a covered service under the *plan*. Such service is either excluded or limited under this *plan*. Please see the "Grievance Process" in this booklet; or
  - (c) The dental service is determined to be not medically necessary. "Medically Necessary Services" means covered dental services which are: (i) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (ii) consistent with nationally accepted standards of practice. Please see the "Utilization Review and Utilization Review Appeal Process" in this booklet.
- (5) A member who receives authorized specialty services must pay all applicable patient charges associated with the services provided.

## Managed DentalGuard - This Plan's Dental Coverage Organization (Cont.)

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When we authorize specialty dental care, a member will be referred to a participating specialist for treatment. The MDG network includes participating specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the member's service area. If there is no participating specialist in the member's service area, we will refer the member to a non-participating specialist of our choice. Except for emergency dental services, in no event will we cover dental care provided to a member by a specialist not pre-authorized by us to provide such services.

A member is entitled to a "standing referral" to a participating specialist and/or, if applicable, a specialty care center under the following conditions:

- (a) upon diagnosis of a life-threatening condition or disease; or
- (b) a degenerative or disabling condition or disease requiring specialized care over a prolonged period.

In all other cases, all specialty referral services must be pre-authorized by us, as stated above.

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### **Emergency Dental Services**

*We provide for emergency dental services twenty-four hours a day, seven days a week, to all members. A member should contact his or her selected and assigned PCD, who will make arrangements for such care. If a member is unable to reach his or her PCD in an emergency during normal business hours, he or she must call our Member Services Department for instructions. If a member is unable to reach his or her PCD in an emergency after normal business hours, the member may seek emergency dental services from any dentist. Then, within 2 business days, the member should call Guardian to advise of the emergency claim. The member must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her PCD. This must be done within 90 days, or as soon as is reasonably possible. We will reimburse the member for the cost of the emergency dental services, less any patient charge which may apply.*

### **Out-Of-Area Emergency Dental Services**

*If a member is more than 50 miles from his or her home and emergency dental services are required, he or she should seek care from a dentist. Then he or she must file a claim within 90 days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating dentist. The statement must list all services provided. We will reimburse the member within 30 days for any covered emergency dental services, up to a maximum of \$50.00 per incident, after payment of any patient charge which may apply.*

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**Overview** *Member* grievances are handled by Guardian's Quality of Care Liaison (QCL) or a person named by him or her. This is done under the supervision of the Dental Director or a person named by him or her. The process is designed to quickly and satisfactorily address *member* concerns. A grievance may be submitted by: (a) a *member*; (b) a person acting on behalf of a *member*; or (c) a *member's dentist*.

A *member* may file a grievance regarding an administrative or a health care concern. A *member* may also use a grievance to seek a reversal of a denial of access to a specialist's care for certain services, or a determination that a procedure or service is not a covered service under the *Plan*. A grievance should not be used to seek a reversal of an adverse Utilization Review determination. An adverse determination is made when the services described in a specialty referral request are found to be not medically necessary.

**Process** Requests for specialty referrals will be reviewed according to *plan* guidelines (See the Specialty Referral section under the heading "Dental Expense Coverage" in this booklet). The *member* and his or her *dentist* will be informed of any denial. This will include, but will not be limited to: (a) access to a referral; or (b) determination that a service or procedure is not a covered service under the *plan*. The *member* or *dentist* may request a re-evaluation of the decision according to the procedures outlined below:

- (1) Questions or concerns may be directed to *us* either by telephone or mail. The *Member Services* Department may be reached at 1-888-618-2016 between 9:30 a.m. and 7:30 p.m., Eastern Time, or by mail to P.O. Box 4391, Woodland Hills, CA 91367. A *member* may leave a message on *our* after hours answering machine. *We* will call back no less than one business day after the call was recorded. The *Member Services* Department includes employees with diverse language ability in order to help *members* who do not speak English. When *member* issues or concerns are received by telephone, the *Member Services Representative* documents the call and works with the *member* to resolve the issue. If the *member* wishes to document the grievance in writing, the *Member Services Representative* sends the *member* a grievance form to complete. If the *member* wishes to submit an oral grievance, the *Member Services Representative* completes the grievance form for him or her. It is mailed to the *member* within 5 business days. The grievance form has prominent instructions which state that the *member* must sign and return the grievance form to the QCL with any amendments, in order to start the grievance resolution process. All written *member* issues are documented and reviewed. The *member*: (a) has the right to name a person to act on his or her behalf to file the grievance; and (b) must inform Guardian in writing of the name of the person acting on his or her behalf at the time the grievance form is submitted.
- (2) Within 15 business days after the receipt of the written grievance, an acknowledgement letter is sent to the *member* indicating that a review is taking place. The letter will state the name, address and telephone number of the QCL.
- (3) Under the supervision of the QCL, supporting documentation is collected. The dental office may be asked to provide copies of relevant dental records and radiographs, if applicable.

## Grievance Process (Cont.)

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- (4) Upon receipt of complete documentation, the grievance is reviewed and a determination is made.
  - a. Determinations of denial of access to a referral will be made by a *dentist* reviewer.
  - b. Determinations that a procedure is not a covered service under this *plan* may be made by qualified personnel.

**Expedited Grievances** Grievances which involve an emergency: (a) are those which possess a significant risk to the *member's* health; and (b) will be concluded in accordance with the denial of immediacy of the case.

We define emergency dental services as bona fide emergency services which are reasonably necessary: (a) to relieve the sudden onset of severe pain, swelling, serious bleeding or severe discomfort; or (b) to prevent the imminent loss of teeth, and are *covered services* under this *plan*.

On receipt of complete documentation, the expedited grievance is reviewed and a determination is made.

- a. Determinations of denial of access to a referral will be made by a *dentist* reviewer.
- b. Determinations that a procedure is not a *covered service* under this *plan* may be made by qualified personnel.

**Timeframes** Timeframes for resolution of grievances are as follows:

**Emergency Grievances:** Within 48 hours from receipt of all necessary information for expedited emergency cases, with written notice to follow within 2 business days.

**Prospective Grievances:** Within 30 days from receipt of all necessary information for: (a) issues involving requests for referrals; or (b) determinations concerning whether a service or procedure is a covered service under the *plan*.

**Retrospective Grievances:** Within 45 days from receipt of all necessary information in all other cases.

**Notification** The notice of a determination of a grievance appeal will include:

- a. the detailed reasons for the determination; and
- b. in cases where the determination has a clinical basis, the clinical rationale for the determination.

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**Grievance Appeals Process** If the *member* is not satisfied with the grievance resolution, he or she may file a written or telephone grievance appeal within 60 business days of receipt of the grievance resolution.

**Standard Grievance Appeals** which involve prospective or retrospective treatment will be acknowledged by *us* within 15 days of receipt. The acknowledgement will include: (a) the name, address and phone number of the person(s) responsible for resolution; and (b) notice of needed additional information, if any, to resolve the grievance appeal.

## Grievance Process (Cont.)

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**Expedited Grievance Appeals** which involve an emergency: (a) are those that pose a significant risk to the *member's* health; and (b) will be resolved within 48 hours of receipt of all necessary information.

The determination of a grievance appeal on a clinical matter will be made by a different *dentist* reviewer than the one involved in the initial grievance resolution. The determination of a non-clinical matter will be resolved by qualified personnel at a higher level than the personnel who made the initial grievance determination.

Following the resolution of the grievance appeal, the *member* and Guardian each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by the *dentist*.

CGP-3-MDG-GRV-NY

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**Files** Each grievance and grievance appeal will be kept on file in *our* Woodland Hills, California office. Grievance files will contain:

- a. the *member's* name and social security number;
- b. the date the grievance was filed;
- c. a copy of the grievance;
- d. the date of *our* receipt of, and a copy of, the *member's* grievance form of the oral grievance which began the grievance process;
- e. a copy of and the date of the grievance determination;
- f. the title and, for a clinical determination, the credentials of the *general* or *specialist dentist* who reviewed the grievance or the grievance appeal, if applicable; and
- g. a copy of the grievance appeal, if applicable.

**Written Notice Of Grievance Process** We will give a *member* written notice of this *plan's* grievance process at any time that *we* deny: (a) access to a specialty referral; or (b) benefits for a service which is not a covered service under this *plan*.

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## Utilization Review and Utilization Review Appeal Process

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**Definitions** "Utilization Review (UR)" means the review of specialty referrals to determine whether dental services are medically necessary. UR does not include: (a) denial of access to a specialty referral, unless the referral is denied for reasons of medical necessity; or (b) a determination that a procedure or service is not a covered service under the *plan*.

"Utilization Review Appeal (URA)" means an appeal of an adverse determination concerning the medical necessity of dental services.

"Adverse Determination (AD)" means a determination by a *general* or *specialist dentist* reviewer, as appropriate, that a dental service is not medically necessary.

## Utilization Review and Utilization Review Appeal Process (Cont.)

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"Medically Necessary Services" means covered dental services which are: (a) adequate, appropriate and essential for the evaluation, diagnosis and treatment of a dental condition or disease; and (b) consistent with nationally accepted standards of practice.

**Overview** Determinations in Utilization Review and the Utilization Review Appeals Process are reviewed by a *general* or *specialist dentist* reviewer, as appropriate. This is done under the supervision of the Dental Director or a person named by him or her. The process is designed to quickly and satisfactorily address *member* concerns. A concern may be submitted by: (a) a *member*; (b) a person acting on behalf of a *member*; or, only in the case of a retrospective AD, (c) a *member's dentist*.

**Policies And Procedures** We perform UR on specialty referral services. When preparing a *member's* treatment plan, a *PCD* may identify the need for more complex treatment which requires the skills of a specialist. All referrals to a specialist must be consistent with a treatment plan that has been communicated to the *member*. The *PCD* must submit a Specialty Referral Form to us for: (a) pre-authorization of all non-emergency treatment; and (b) approval of referral of a *member* to a specialist. This process allows us to monitor the frequency and appropriateness of the requested treatment. We have established Specialty Referral Guidelines for *participating dentists*. These guidelines include procedures for authorization and payment of specialty referrals.

Specialty referrals which may be denied for medical necessity will follow the process described below.

We do not require pre-authorization of *PCD* services. However, if a *PCD* or a *member* requests pre-authorization of a *PCD* service, and the service is denied for medical necessity, the process set forth for appealing specialty referrals will apply.

**Process** Services which may be denied for medical necessity are to be handled by a *general* or *specialist dentist* reviewer, as appropriate. The *member* or his or her *dentist* may contact the QCL at 1-888-618-2016 between 9:30 a.m. and 7:30 p.m., Eastern Time, or by mail to P.O. Box 4391, Woodland Hills, CA 91367 to request a URA.

### Time Frames For UR Determinations

#### A. Prospective Determinations

**Standard:** All proposed specialty referrals are to be evaluated. We will inform the *dentist* and the *member* of the result of the review by telephone and in writing. This will be done within 3 business days from the receipt of all necessary documentation.

**Expedited:** All proposed specialty referrals are to be evaluated. We will inform the *dentist* and the *member* of the result of the review by telephone and in writing. This will be done within 2 business days from the receipt of all necessary documentation.

## Utilization Review and Utilization Review Appeal Process (Cont.)

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**B. Concurrent Determinations:** We will inform the *dentist* and the *member* of determinations of medical necessity of specialty referrals which involve continued or on-going treatment by telephone and in writing. This will be done within one business day from receipt of all necessary documentation. Notification of continued or extended services will include: (a) the number of extended services approved; (b) the new total of approved services; (c) the date of onset of services; and (d) the next review date.

**C. Retrospective Determinations:** We may require a retrospective review if services authorized in advance are not performed as originally authorized. We will inform the *dentist* and the *member* of the determination of the medical necessity of a specialty referral which involves retrospective review in writing. This will be done within 30 days of receipt of all necessary documentation.

**Notification of UR Determinations** We will inform the *member* and the *dentist* by telephone and in writing of an AD. Written notice of an AD will:

1. state the reasons for the denial, including the clinical rationale;
2. include the URA process and appeal rights, including the *member's* right to an external appeal;
3. indicate that the review criteria are available upon request; and
4. indicate what additional necessary information must be provided in order to render a decision on appeal.

**Reconsideration Process** If there was no telephone discussion at the time of the initial AD, a telephone discussion will take place between the *member's dentist* and the *dentist* reviewer who made the AD. If the *dentist* reviewer who made the AD is not available, a different *dentist* will be available for the telephone discussion. Additional information may be provided or requested.

**Prospective and Concurrent Reconsiderations** will take place within one business day of receipt of the request and of all necessary documentation.

**Retrospective Reconsiderations** will take place within 30 days of receipt of the request and of all necessary documentation.

Reconsiderations that are denied may be further appealed through the Plan's standard appeal process.

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**URA Process** If a *member* or *dentist* has utilized the Reconsideration Process and is still dissatisfied with the outcome, the *dentist* or *member* may: (a) request that an initial AD or reconsideration be further re-evaluated (i.e., a URA); and (b) submit additional information for the re-evaluation. The Standard and Expedited URA Review will be reviewed by a *dentist* reviewer other than the original *dentist* reviewer.

## Utilization Review and Utilization Review Appeal Process (Cont.)

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**Standard Process** URAs may be received by telephone or in writing. The *member* or his or her *dentist* may file an appeal with the *plan* within 45 days from the date of the initial review determination and receipt of all necessary information to file an appeal. The *dentist* reviewer will acknowledge the appeal in writing. He or she will include: (a) the name, address and telephone number of the person named by the *plan* to respond to the appeal; and (b) a request for any additional necessary information which must be provided in order to render a decision. This will be done within 15 days of receipt of the appeal. A determination will be made within 60 days of receipt of all necessary information. The *dentist* and/or *member* will be notified of the determination of the appeal within 2 business days of the decision. The reasons for the determination will be included. If the AD is upheld on appeal, the notice will also include the clinical rationale for such determination, as well as the notice of the *member's* right to an external appeal.

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**Expedited Process** Expedited URAs may be received by telephone or in writing. The expedited appeal process may be used for: (a) continued or extended dental care services; or (b) an AD when the *member's dentist* believes an immediate appeal is warranted. Expedited appeals are not used for retrospective ADs. Within one business day of receipt of the notice of appeal, the *member* or *dentist* will have reasonable access to the *dentist* reviewer to make it easier to submit any added information in support of the appeal. Determination will be made within 2 business days of receipt of necessary information. Expedited appeals that are denied may be further appealed through the *plan's* standard appeal process. *Members* may also have the right to request an external appeal, as described in the following section.

**External Appeal** *You* and/or your *dentist* have the right to external appeal of a final adverse determination after exhausting our internal review processes. *You* or your *dentist* may request an external appeal of a final AD by our internal appeal process, when:

## Utilization Review and Utilization Review Appeal Process (Cont.)

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- (1) A procedure that would otherwise be a covered service under the *plan* is denied on appeal, in whole or in part, on the grounds that such procedure is not medically necessary; and (a) Guardian has rendered a final AD with respect to such procedures; or (b) both *you* and Guardian have jointly agreed to waive any internal appeal; or
- (2) Coverage of a procedure was denied on the basis that such procedure is experimental or investigational, and such denial has been upheld on appeal; or your *dentist* has certified that *you* have a life-threatening or disabling condition or disease:
  - i) for which standard dental services or procedures have been ineffective or would be medically inappropriate; or
  - ii) for which there does not exist a more beneficial standard dental service or procedure covered by the *plan*; or
  - iii) for which there exists a clinical trial; andYour *dentist* must have recommended either:
  - i) a dental treatment, based on two documents from the available dental and scientific evidence, is likely to be more beneficial to *you* than any covered, standard dental procedure; or
  - ii) a clinical trial for which *you* are eligible.

An external appeal must be initiated in writing within 45 days after the *member* receives notification of the final adverse determination. The notification letter will include instructions for initiating an external appeal.

Any *dentist* certification provided under this section will include a statement of the evidence relied upon by the *dentist* in certifying his or her recommendation. And the specific dental procedure recommended by the *dentist* would otherwise be covered under the *plan* except for Guardian's determination that the dental procedure is experimental or investigational.

Guardian may charge *you* a fee of up to \$50 per external appeal. This fee is refundable to *you* in the event the external appeal agent overturns Guardian's final adverse determination. Guardian will not require *you* to pay any such fee if such fee will pose a hardship to *you*, as determined by Guardian.

Following the decisions of the *dentist* reviewer, *you* and Guardian each have the right to use the legal system for any claim involving the professional treatment performed by a *participating dentist* after the *plan's* internal and external review processes have been exhausted.

CGP-3-MDG-UR-NY2

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## Covered Dental Services And Patient Charges - Schedule 3NYM

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *member's PCD*.

The *member* must pay the listed *patient charge*. Guardian covers the rest of the *participating dentist's* charge for the service. The benefits we provide are subject to all of the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions.

These *patient charges* are only valid for covered services rendered by *participating dentists* in the State of New York.

MDG Codes+	Description of Service	Patient Charge
<b>Appointments and Diagnostic Services</b>		
0101	Office Visit - during regular hours - participating general dentist only . .	\$5.00
0102	Broken Appointment (without 24 hours notice) . . . . .	\$20.00
0120, 0140, 0150	Oral evaluation . . . . .	No Charge
0460	Pulp vitality tests . . . . .	No Charge
0470	Diagnostic casts . . . . .	No Charge
9310	Consultation (by dentist other than practitioner providing treatment) . . . . .	\$30.00
9430	Office visit for observation - regular hours - no other service performed . . . . .	No Charge
9440	Emergency office visit - after regularly scheduled office hours . . . . .	\$20.00
<b>Radiographs</b>		
0210	Intraoral - complete series (including bitewings) . . . . .	No Charge
0220, 0230, 0240	Intraoral - periapical or occlusal - single film . . . . .	No Charge
0270, 0272, 0274	Bitewings . . . . .	No Charge
0330	Panoramic film . . . . .	No Charge
<b>Preventive Services &amp; Space Maintenance</b>		
1110, 1120	Prophylaxis . . . . .	No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child . .	No Charge
1310	Nutritional instruction for control of dental diseases . . . . .	No Charge
1330	Oral hygiene instruction . . . . .	No Charge
1351	Sealant - per tooth . . . . .	\$8.00
1510	Space maintainer - fixed - unilateral . . . . .	\$54.00
1515	Space maintainer - fixed - bilateral . . . . .	\$72.00
1550	Recementation of space maintainer . . . . .	\$12.00
<b>Restorative</b>		
2110	Amalgam - one surface - primary . . . . .	\$15.00
2120	Amalgam - two surfaces - primary . . . . .	\$19.00
2130	Amalgam - three surfaces - primary . . . . .	\$23.00
2131	Amalgam - four or more surfaces - primary . . . . .	\$28.00
2140	Amalgam - one surface - permanent . . . . .	\$17.00
2150	Amalgam - two surfaces - permanent . . . . .	\$22.00

## Covered Dental Services And Patient Charges - Schedule 3NYM (Cont.)

2160	Amalgam - three surfaces - permanent	\$26.00
2161	Amalgam - four or more surfaces - permanent	\$32.00
2210	Silicate cement - per restoration	\$15.00
2330	Resin/composite - one surface, anterior	\$20.00
2331	Resin/composite - two surfaces, anterior	\$26.00
2332	Resin/composite - three surfaces, anterior	\$32.00
2335	Resin/composite - four or more surfaces or incisal angle, anterior	\$38.00
2336	Composite resin crown, anterior - primary	\$95.00
2380	Resin/composite - one surface, posterior - primary	\$55.00
2381	Resin/composite - two surfaces, posterior - primary	\$65.00
2382	Resin/composite - three or more surfaces, posterior - primary	\$80.00
2385	Resin/composite - one surface, posterior - permanent	\$56.00
2386	Resin/composite - two surfaces, posterior - permanent	\$75.00
2387	Resin/composite - three or more surfaces, posterior - permanent	\$95.00

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

\* If high noble metal is used, there will be an additional charge for the actual cost of the high noble metal used.

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### Crown, Bridge & Other Cast Restorations

2510	Inlay - metallic - one surface*	\$280.00
2520, 6520	Inlay - metallic - two surfaces*	\$320.00
2530, 6530	Inlay - metallic - three or more surfaces*	\$370.00
2543, 6543	Onlay - metallic - three surfaces*	\$380.00
2544, 6544	Onlay - metallic - four or more surfaces*	\$395.00
2702	Crown supporting existing partial denture - in addition to crown	\$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	\$125.00
2740	Crown - porcelain/ceramic substrate	\$395.00
2750, 2751, 2752	Crown - porcelain fused to metal*	\$395.00
2790, 2791, 2792	Crown - full cast metal*	\$395.00
2810, 6780	Crown - 3/4 cast metallic*	\$395.00
6210, 6211, 6212	Pontic - cast metal*	\$385.00
6240, 6241, 6242	Pontic - porcelain fused to metal*	\$385.00
6750, 6751, 6752	Crown - abutment - porcelain fused to metal*	\$395.00
6790, 6791, 6792	Crown - abutment - full cast metal*	\$395.00

### Other Restorative Services

2910, 2920, 6930	Recementation inlay, crown, bridge	\$18.00
2930, 2931	Prefabricated stainless steel crown	\$110.00
2932	Prefabricated resin crown	\$135.00
2940	Sedative filling	\$17.00
2950, 6973	Core buildup, including any pins	\$100.00
2951	Pin retention - per tooth, in addition to restoration	\$22.00
2952, 6970	Cast post & core	\$155.00
2954, 6972	Prefabricated post & core	\$125.00
2960	Labial veneer (laminare) - chairside	\$295.00

### Endodontics

3110, 3120	Pulp cap	\$10.00
3220	Therapeutic pulpotomy	\$25.00
3310	Root canal - anterior	\$120.00
3320	Root canal - bicuspid	\$145.00

## Covered Dental Services And Patient Charges - Schedule 3NYM (Cont.)

<b>3330</b>	Root canal - molar . . . . .	\$370.00
<b>3346</b>	Root canal - retreatment - anterior . . . . .	\$315.00
<b>3347</b>	Root canal - retreatment - bicuspid . . . . .	\$370.00
<b>3348</b>	Root canal - retreatment - molar . . . . .	\$445.00
<b>3410</b>	Apicoectomy/periradicular surgery - anterior . . . . .	\$265.00
<b>3421</b>	Apicoectomy/periradicular surgery - bicuspid - first root . . . . .	\$300.00
<b>3425</b>	Apicoectomy/periradicular surgery - molar - first root . . . . .	\$350.00
<b>3426</b>	Apicoectomy/periradicular surgery - each additional root . . . . .	\$110.00
<b>3430</b>	Retrograde filling - per root . . . . .	\$80.00

### Periodontics

<b>4210</b>	Gingivectomy or gingivoplasty - per quadrant . . . . .	\$235.00
<b>4211</b>	Gingivectomy or gingivoplasty - per tooth . . . . .	\$60.00
<b>4240</b>	Gingival flap procedure - including root planing - per quadrant . . . . .	\$275.00
<b>4249</b>	Clinical crown lengthening - hard tissue . . . . .	\$275.00
<b>4260</b>	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth . . . . .	\$392.00
<b>4261</b>	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth . . . . .	\$235.00
<b>4270</b>	Pedicle soft tissue graft procedure . . . . .	\$290.00
<b>4271</b>	Free soft tissue graft procedure (including donor site surgery) . . . . .	\$298.00
<b>4341</b>	Periodontal scaling & root planing - per quadrant . . . . .	\$40.00
<b>4355</b>	Full mouth debridement to enable evaluation and diagnosis . . . . .	\$24.00
<b>4910</b>	Periodontal maintenance procedures (following active therapy) . . . . .	\$22.00
<b>4920</b>	Unscheduled dressing change (by other than treating dentist) . . . . .	\$19.00
<b>9951</b>	Occlusal adjustment - limited - per visit . . . . .	\$20.00

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

\* If high noble metal is used, there will be an additional charge for the actual cost of the high noble metal used.

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### Prosthodontics (Removable)

<b>5110, 5120</b>	Complete denture (including routine post delivery care) . . . . .	\$452.00
<b>5130, 5140</b>	Immediate denture (including routine post delivery care) . . . . .	\$492.00

#### Partial dentures (including routine post delivery care):

<b>5211</b>	Upper partial, resin base - including clasps, rests, teeth . . . . .	\$381.00
<b>5212</b>	Lower partial, resin base - including clasps, rests, teeth . . . . .	\$443.00
<b>5213, 5214</b>	Cast metal framework with resin base - including clasps, rests, teeth . . . . .	\$500.00

#### Repairs and adjustments:

<b>5410, 5411, 5421, 5422</b>	Denture adjustments . . . . .	\$25.00
<b>5510</b>	Repair broken denture base . . . . .	\$50.00
<b>5520, 5640</b>	Replace missing or broken teeth -per tooth . . . . .	\$45.00
<b>5610</b>	Repair resin denture base . . . . .	\$55.00
<b>5630</b>	Repair or replace clasp . . . . .	\$70.00
<b>5650</b>	Add tooth to existing partial . . . . .	\$65.00
<b>5660</b>	Add clasp to existing partial . . . . .	\$80.00

**Covered Dental Services And Patient Charges - Schedule 3NYM (Cont.)**

5710, 5711, 5720, 5721	Rebase denture . . . . .	\$200.00
5730, 5731, 5740, 5741	Reline denture (chairside) . . . . .	\$110.00
5750, 5751, 5760, 5761	Reline denture (laboratory) . . . . .	\$150.00
5820, 5821	Interim partial denture (stayplate) . . . . .	\$175.00
5850, 5851	Tissue conditioning . . . . .	\$45.00

**Oral Surgery**

7110, 7120	Extraction - single tooth . . . . .	\$22.00
7130	Root removal - exposed roots . . . . .	\$30.00
7210	Surgical removal of erupted tooth . . . . .	\$90.00
7220	Removal of impacted tooth - soft tissue . . . . .	\$115.00
7230	Removal of impacted tooth - partially bony . . . . .	\$150.00
7240	Removal of impacted tooth - completely bony . . . . .	\$180.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications . . . . .	\$225.00
7250	Surgical removal of residual tooth roots (cutting procedure) . . . . .	\$95.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$210.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons . . . . .	\$230.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption . .	\$195.00
7285	Biopsy of oral tissue - hard . . . . .	\$125.00
7286	Biopsy of oral tissue - soft . . . . .	\$85.00
7310	Alveoplasty in conjunction with extractions - per quadrant . . . . .	\$105.00
7320	Alveoplasty not in conjunction with extractions - per quadrant . . . . .	\$140.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm . . . . .	\$350.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm . . . . .	\$540.00
7510	Incision & drainage of intraoral abscess . . . . .	\$105.00
7960	Frenulectomy (separate procedure) . . . . .	\$230.00

**Miscellaneous Services**

9110	Palliative (emergency) treatment - per visit . . . . .	\$20.00
9215	Local anesthesia . . . . .	No Charge

+ Covered services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe covered services.

\* If high noble metal is used, there will be an additional charge for the actual cost of the high noble metal used.

CGP-3-MDG-L3-NY-FCW

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MDG CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
<b>Orthodontic Services</b>		
8601	Orthodontic evaluation and consultation . . . . .	\$100.00
8602	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos . . . . .	\$150.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: <i>dependent</i> child to age 18 (as determined by the <i>member's</i> age on the date of banding) . . . . .	\$2425.00

## Covered Dental Services And Patient Charges (Cont.)

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<b>8070, 8080, 8090</b>	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: <i>employee</i> , spouse or <i>dependent</i> child over age 18 (as determined by the <i>member's</i> age on the date of banding) . . . . .	\$2425.00
<b>8670</b>	Periodic comprehensive orthodontic treatment visit . . . . .	No Charge
<b>8680</b>	Orthodontic retention . . . . .	\$425.00

+ Covered Services are subject to this *plan's* exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

\* These orthodontic *patient charges* are valid only for authorized services rendered by *participating orthodontists* in the State of New York.

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## Additional Conditions On Covered Services

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**General Guidelines For Alternative Procedures** More than one procedure may be appropriate for treating a dental condition. A *member* may choose an appropriate alternative procedure over the service recommended by the PCD. If the alternative procedure is covered under the plan, the *member* pays the patient charge for that procedure. If the alternative procedure is not covered under the plan, the PCD may charge his or her usual and customary fee for the non-covered service.

Whenever there is more than once course of treatment available, a full disclosure of all the options must be given to the member before treatment begins. The PCD should present the *member* with a treatment plan in writing before treatment begins, to assure that there is no confusion over what the member must pay.

**Crowns, Bridges And Dentures** The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan*.

The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by relining, rebase or repair. Construction of new dentures may not exceed one new denture in any 5 year period from the date of previous placement under the *plan*.

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for six months; and (b) does not include required future rebasing or relining procedures or a complete new denture.

**Multiple Crown/Bridge Unit Treatment Fee** A *member's* recommended treatment plan may include 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the *member* must pay both: (a) the usual crown or bridge *patient charge* for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Covered Dental Services And Patient Charges section.

## Additional Conditions On Covered Services (Cont.)

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**Crown Supporting Existing Partial Denture** A crown may be: (a) placed under an existing partial denture; and (b) be customized to physically support the metal framework of the partial denture. In such case, the *member* must pay the additional *patient charge* for a crown supporting an existing partial denture. This charge is shown in the Covered Dental Services And Patient Charges section. This charge is in addition to the *patient charge* for the crown or bridge unit itself. The *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* must pay the *patient charge* for a multiple crown/bridge unit treatment plan.

**Pediatric Specialty Services** During a *PCD* visit, a *member* under age 6 may be unmanageable. In such case, the *member* may be referred to a *participating pediatric specialist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *PCD* for further services. Subsequent referrals to the *participating pediatric specialist*, if any, must first be authorized by us. Any services performed by a *pediatric specialist* after the *member's* 6th birthday will not be covered. And the *member* must pay the *pediatric specialist's* usual charges.

**Second Opinion Consultation** A *member* may wish to consult another *dentist* for a second opinion regarding services recommended or performed by: (a) his or her *PCD*; or (b) a *participating specialist* through an authorized referral. To have a second opinion consultation covered by us, the *member* must call or write to *Member Services* for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the *plan*.

A *Member Services Representative* will help the *member* identify a *participating dentist* to perform the second opinion consultation. A *member* may request a second opinion with a *non-participating general dentist* or *specialist dentist*. Also, the *Member Services Representative* will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting *dentist*. The *plan's* benefit for a second opinion consultation is limited to \$50.00. If a *participating dentist* is the consultant, there is no cost to the *member*. If a *non-participating dentist* is the consultant, the *member* must pay any portion of his or her fee over \$50.00.

**Noble And High Noble Metals** The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the *member* must pay: (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; and (b) an added charge equal to the actual laboratory cost of the high noble metal.

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**Orthodontic Services** This *plan* covers orthodontic services as listed under Covered Dental Services And Patient Charges. Coverage is limited to one course of treatment per *member* per lifetime. Treatment must be: (a) preauthorized by us; and (b) performed by a participating orthodontist.

## Additional Conditions On Covered Services (Cont.)

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The Plan covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, the *member* must pay an added charge for each added month of treatment. Such charge is based on the Participating Orthodontist's contracted fee. If treatment beyond 36 months is required, the contracted fee will no longer apply. The Participating Orthodontist may then charge a prorated charge based on his or her usual fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the plan. If a *member's* coverage terminates after the fixed banding appliances are inserted, the Participating Orthodontist may prorate his or her usual fee over the remaining months of treatment. The *member* is responsible for all payments to the Participating Orthodontist after the termination date.

After the termination date, the member must pay only the usual patient charge for comprehensive orthodontic treatment.

If a *member* transfers to another participating orthodontist after comprehensive orthodontic treatment has been started, he or she must pay any added costs associated with: (a) the change in orthodontist; and (b) subsequent treatment.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. The *member* must pay for any additional fixed or removable appliances. The benefit for orthodontic retention covers: (a) any and all necessary fixed and removable appliances; and (b) related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances made with: (a) clear; (b) ceramic; (c) white or other optional material; or (d) lingual brackets. The *member* must pay any added costs for the use of optional materials.

If a *member* has orthodontic treatment associated with orthognathic surgery, the *plan* provides its standard orthodontic benefit. Orthognathic surgery is a non-covered procedure which involves the surgical moving of teeth. The *member* must pay any added charges related to: (a) the orthognathic surgery; and (b) the complexity of the orthodontic treatment. The added charges will be based on the participating orthodontist's usual and customary charge.

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### Limitations On Benefits For Specific Covered Services

We don't cover services in excess of any of the following limitations:

- Routine cleaning (prophylaxis) or periodontal maintenance procedure - 2 services in any 12 month period. One periodontal maintenance procedure may be performed by a *participating periodontist* if done within 3 to 6 months following completion of approved, active periodontal therapy by the *participating periodontist*. Such therapy includes periodontal scaling and root planing or periodontal surgery.
- Fluoride treatment - up to the 18th birthday - 2 in any 12 month period.

## Additional Conditions On Covered Services (Cont.)

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- Full mouth x-rays - one set in any 3 year period unless diagnostically necessary.
- Bitewing x-rays - 2 sets in any 12 month period unless diagnostically necessary.
- Panoramic x-rays - one in any 3 year period unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one per tooth in any 3 year period.
- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one procedure per quadrant or area in any 3 year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one service per area in any 3 year period.
- Periodontal scaling and root planing - one service per quadrant in any 12 month period.
- *Emergency dental services* when more than 50 miles from the *member's* home - up to \$50.00 per incident, after payment of any *patient charge* which may apply.
- Reline of a complete or partial denture - one per denture in any 12 month period.
- Rebase of a complete or partial denture - one per denture in any 12 month period.
- Second opinion consultation - when approved by *us*, up to \$50.00.

CGP-3-MDG-LMT-FCW

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## Exclusions

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We won't cover:

- any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease law, or under any other non-dental insurance or benefit plan. This will apply even if the *member* fails to claim his or her rights to such benefit.
- dental services performed in a hospital or related hospital fees, or charges for the use of any facility, equipment or supplies provided outside of the *participating dentist's* office.
- any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.
- any treatment of congenital and/or developmental malformations. This will not apply to an otherwise covered service involving congenitally missing teeth or supernumerary teeth.
- any oral surgery requiring the setting of a fracture or dislocation.

## Exclusions (Cont.)

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- dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- any treatment or appliance: (a) which, in the opinion of the *participating dentist*, Guardian's dental director or his or her authorized agent will not achieve a satisfactory result; or (b) which is solely for cosmetic purposes.
- precision attachments, stress breakers, magnetic retention or overdenture attachments.
- the use of: (a) general anesthesia; (b) intramuscular sedation; (c) intravenous sedation; or (d) inhalation sedation, including but not limited to nitrous oxide.
- any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature, unless coverage is recommended by a utilization review agent.
- replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.
- any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD*; or (b) treatment by a specialist without referral from the *PCD* and *our* approval.
- treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless *we* are legally required to provide benefits.
- any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; (c) splint or stabilize teeth for periodontal reasons; or (d) realign teeth.
- any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- dental services received from any *dentist* other than the selected and assigned *PCD*, unless expressly authorized in writing by the *plan*. This will not apply to *emergency dental services*.
- cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- treatment which requires the services of a prosthodontist.
- treatment which requires the services of a *pediatric specialist*, after the *member's* 6th birthday.
- consultations for non-covered services.
- any procedure not listed as a covered service.
- any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.

## Exclusions (Cont.)

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- a service started but not completed prior to the *member's* eligibility to receive benefits under the *plan*. Inlays, onlays and fixed bridges are considered started when the tooth or teeth are prepared. Root canal treatment is considered started when the pulp chamber is opened. Orthodontics are considered started at the time of initial banding. Dentures are considered started when the impressions are taken.
- a service started (as defined above) by a *non-participating dentist*. This will not apply to covered *emergency dental services*.
- extractions performed solely to facilitate orthodontic treatment.
- extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- orthognathic surgery and associated incremental charges. Orthognathic surgery is a procedure which involves the surgical moving of teeth.
- procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- replacement or repair of orthodontic appliances damaged due to the neglect of the *member*.

CGP-3-MDG-EXC-B-FCW 11/00

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## GLOSSARY

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This Glossary defines the italicized terms appearing in this booklet.

**Alternative Procedure** means a service other than that recommended by the *member's PCD*. But, in the opinion of the *PCD*, such procedure is also an acceptable treatment for the *member's* dental condition.

CGP-3-MDG-DEF1

B850.0595-R

**Certificate Of Coverage** means this booklet issued to *you*, which summarizes the essential terms of this *plan*.

CGP-3-MDG-DEF2

B850.0596-R

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

CGP-3-MDG-DEF3

B850.0597-R

**Dependent** means a person listed on your enrollment form who is any of the following:

- (1) your spouse;
- (2) your or your spouse's unmarried *dependent child* who:
  - (a) is less than 19 years of age, or less than 25 if a full-time student; and
  - (b) depends primarily on *you* or your spouse for support and maintenance.

The term "*dependent child*" as used in this *plan* will include any: (a) stepchild; (b) newborn child; (c) legally adopted child; (d) child for whom *you* are court-appointed legal guardian; or (e) proposed adoptive child, during any waiting period prior to the formal adoption if the child: (i) is a part of your household, and (ii) is primarily dependent on *you* for support and maintenance. The term also includes any child for whom a court-ordered decree requires *you* to provide *dependent* coverage.

- (3) A mentally retarded or physically handicapped *dependent child* who: (1) has reached the upper age limit of a *dependent child*; (2) is not capable of self-sustaining work; and (3) depends primarily on *you* for support and maintenance. *You* must furnish proof of such lack of capacity and dependence to us within 31 days after the child reaches the limiting age, and each year after that, on *our* request;
- (4) Your domestic partner, who may be treated as a spouse under this *plan*, subject to the conditions below:

For a domestic partner to be treated as a spouse under this *plan*, both *you* and your 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 your 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.

*You* must complete a "Declaration of Domestic Partnership" attesting to the relationship.

Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with your *employer*. Once *you* submit a "Statement of Termination," *you* may not enroll another domestic partner for a period of 12 months from the date of the previous termination. And, the domestic partner will not be eligible for continuation of dental coverage as explained: (a) under the "Federal Continuation Rights" section; and (b) under any other continuation rights section of this *plan*, unless *you* are also eligible for and elect continuation.

The term "*dependent*" does not include a person who is also covered as an *employee* for benefits under any dental plan which your *employer* offers, including this one.

<b>Emergency Dental Services</b>	mean only covered, bona fide emergency services which are reasonably necessary to: (a) relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort; or (b) prevent the imminent loss of teeth. Services related to the initial emergency condition that are not bona fide emergency services, as described above, are not considered <i>emergency dental services</i> . This includes: (a) services performed at the emergency visit; and (b) services performed at later visits.	CGP-3-MDG-DEF5	B850.0604-R
<b>Employee or You</b>	means the person to whom this booklet is issued: (a) who meets your <i>employer's</i> eligibility requirements; and (b) for whom monthly payments are made by your <i>employer</i> .	CGP-3-MDG-DEF6	B850.0605-R
<b>Employer Or Planholder</b>	means the <i>employer</i> or other entity: (a) with whom or to whom this <i>plan</i> is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its <i>members</i> .	CGP-3-MDG-DEF7	B850.0606-R
<b>Member</b>	means <i>you</i> and any of your eligible <i>dependents</i> : (a) as defined under the eligibility requirements of this <i>plan</i> ; and (b) as determined by your <i>employer</i> , who are actually enrolled in and eligible to receive benefits under this <i>plan</i> .	CGP-3-MDG-DEF8	B850.0607-R
<b>Non-Participating Dentist</b>	means any <i>dentist</i> that does not have an MDG participation agreement in force with <i>us</i> to provide dental services to <i>members</i> .	CGP-3-MDG-DEF9	B850.0608-R
<b>Participating Dentist</b>	means a <i>dentist</i> who has an MDG participation agreement in force with <i>us</i> . This term includes any hygienist and technician recognized by the dental profession who assists and acts under the supervision of a <i>participating dentist</i> .	CGP-3-MDG-DEF10	B850.0609-R
<b>Participating General Dentist</b>	means a <i>dentist</i> who has an MDG participation agreement in force with <i>us</i> : (a) who is listed in MDG's directory of <i>participating dentists</i> as a general practice <i>dentist</i> ; and (b) who may be selected as a <i>PCD</i> by a <i>member</i> and assigned by MDG to provide or arrange for a <i>member's</i> dental services.	CGP-3-MDG-DEF11	B850.0610-R
<b>Participating Specialist</b>	means a <i>dentist</i> who has an MDG participation agreement in force with <i>us</i> as an: (a) <i>Endodontist</i> ; (b) <i>Pediatric Specialist</i> ; (c) <i>Periodontist</i> ; (d) <i>Oral Surgeon</i> ; or (e) <i>Orthodontist</i> .	CGP-3-MDG-DEF12B	B850.0612-R
<b>Patient Charge</b>	means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this <i>plan</i> . Such amount is the patient's portion of the cost of covered dental services.	CGP-3-MDG-DEF13	B850.0613-R

## Glossary (Cont.)

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<b>Plan</b>	means the Guardian <i>plan</i> of group dental benefits described in this booklet.
	CGP-3-MDG-DEF14 B850.0614-R
<b>Primary Care Dentist (PCD)</b>	means a dental office location: (a) at which one or more <i>participating general dentists</i> provide <i>covered services</i> to <i>members</i> ; and (b) which has been selected by a <i>member</i> and assigned by MDG to provide and arrange for his or her dental services.
	CGP-3-MDG-DEF15 B850.0615-R
<b>Service Area</b>	means the geographic area in which we are licensed to provide dental services for <i>members</i> .
	CGP-3-MDG-DEF16 B850.0616-R
<b>We, Us, Our And Guardian</b>	mean The Guardian Life Insurance Company of America.
	CGP-3-MDG-DEF17 B850.0617-R

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## COORDINATION OF BENEFITS

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### Applicability

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This Coordination of Benefits provision applies when a *member* has dental coverage under more than one plan.

When a *member* has dental coverage from more than one plan, this *plan* coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated.

As used here:

"Plan" means any of the following that provides dental expense benefits or services:

- (1) group or blanket insurance plans;
- (2) group coverage under prepayment, group practice and individual practice plans;
- (3) union welfare plans, employer plans, employee benefits plans, trustee labor and management plans, or other plans for members of a group; and
- (4) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other government program or coverage which *we* are not allowed to coordinate with by law. Plan also does not include blanket school accident-type coverage.

"This *plan*" means the part of this *plan* subject to this provision.

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### How This Provision Works: The Order of Benefits

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

In applying this provision, one of the plans is called the primary plan. A secondary plan is one which is not a primary plan. The primary plan pays first, ignoring all other plans. If a *member* is covered by more than one secondary plan, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that secondary plan.

If a plan has no coordination provision, it is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

- (1) A plan that covers a *member* as an *employee* pays first, the plan that covers a *member* as a *dependent* pays second;

## How This Provision Works: The Order of Benefits (Cont.)

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- (2) Except for *dependent* children of separated or divorced parents, the following governs which plan pays first when this *plan* and another plan cover the same child as a *dependent*:
- (a) The benefits of the plan of the parent whose birthday falls earlier in the calendar year pays first. The plan that covers a *dependent* child of the parent whose birthday falls later in the calendar year pays second; but
  - (b) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the other plan.
  - (c) If the benefits of the plan with which we're coordinating does not have a similar provision, then (b) will not apply and the other plan's coordination provision will determine the order of benefits.

"Birthday" refers only to month and day in a calendar year, not the year in which the parent was born.

- (3) For a *dependent* child of separated or divorced parents, benefits for that child are determined in this order:
- (a) first, the plan of the parent with custody of the child;
  - (b) then, the plan of the spouse of the parent with custody of the child;
  - (c) finally, the plan of the parent not having custody of the child; and
  - (d) if the specific terms of a court order state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. This paragraph does not apply with respect to any plan year during which any benefits are actually paid or provided before the entity has that actual knowledge.
- (4) A plan that covers a *member* as an active *employee* or as a *dependent* of such *employee* pays first. A plan that covers a person as a laid-off or retired *employee* or as a *dependent* of such *employee* pays second.

If the plan with which we're coordinating does not have a similar provision for such persons, then (4) will not apply.

If rules (1), (2), (3) and (4) don't determine which plan pays first, the plan that has covered the person for the longer time pays first.

To determine the length of time a *member* has been insured under a plan, two plans will be treated as one if the *member* was eligible under the second within 24 hours after the first plan ended.

The *member's* length of time covered under one plan is measured from his or her first date of coverage under the plan. If that date is not readily available, the date the *member* first became a *member* of the group will be used.

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## How This Provision Works: Coordination of Benefits

**Coordination With A Pre-Paid Dental Plan** A *member* may also be covered under a pre-paid dental plan where *members* pay only a fixed payment amount for each covered service.

For *PCDs'* services, when the *PCD* participates under both plans, the *member* will never have to pay more than this *plan's patient charge*.

For *PCDs'* services when the *PCD* participates under this *plan* only:

- when this *plan* is primary, the *PCD* submits a claim to the secondary plan for the *patient charge* amount. Any payment made by the secondary carrier must be deducted from the *member's* payment.
- when this *plan* is secondary, the *PCD* submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the *patient charge*, reducing the *member's* out-of-pocket expense.

For *participating specialists'* services and *emergency dental services* within the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, any payment made by the primary carrier is credited against the *patient charge*. In many cases, the *member* will have no out-of-pocket expenses.

For *emergency dental services* outside the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this plan is secondary, we pay for covered services not paid by the primary plan, up to \$50.00, after payment of any *patient charge* which may apply.

**Coordination With An Indemnity Or PPO Dental Plan** When a *member* is covered by this plan and a fee-for-service plan, the rules which follow will apply:

For *PCDs'* services:

- when this *plan* is primary, the *PCD* submits a claim to the secondary plan for the *patient charge* amount. Any payment made by the secondary carrier must be deducted from the *member's* payment.
- when this *plan* is secondary, the *PCD* submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the *patient charge*, reducing the *member's* out-of-pocket expense.

For *participating specialists'* services and *emergency dental services* within the *service area*:

- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, any payment made by the primary carrier is credited against the *patient charge*, reducing the *member's* out-of-pocket expense.

For *emergency dental services* outside the *service area*:

## How This Provision Works: Coordination of Benefits (Cont.)

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- when this *plan* is primary, *our* benefits are paid without regard to the other coverage.
- when this *plan* is secondary, *we* pay for covered services not paid by the primary plan, up to \$50.00, after payment of any *patient charge* which may apply.

## Our Right To Certain Information

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In order to coordinate benefits, *we* need certain information. A *member* must supply *us* with as much of that information as he or she can. If he or she can't give *us* all the information *we* need, *we* have the right to get this information from any source. If another insurer needs information to apply its coordination provision, *we* have the right to give that insurer such information. If *we* give or get information under this section, *we* can't be held liable for such action except as required by law.

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

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B850.0619-R

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## STATEMENT OF ERISA RIGHTS

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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:

- (a) Examine, without charge, all *plan* documents, including contracts, collective bargaining agreements and copies of all documents filed by the *plan* with the U.S. Department of Labor, such as detailed annual reports and *plan* descriptions. The documents may be examined at the *plan* Administrator's office and at other specified locations such as worksites and union halls.
- (b) Obtain copies of all *plan* documents and other *plan* information upon written request to the Plan Administrator, who may make a reasonable charge for the copies.
- (c) Receive a summary of the *plan's* annual financial report from the Plan Administrator (if such a report is required).

In addition to creating rights for *plan* participants, ERISA imposes duties upon the people, called "fiduciaries," who are responsible for the operation of your benefit *plan*. They have a duty to operate the *plan* prudently and in the interest of *plan* participants and beneficiaries. Your *employer* may not fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must send him or her a written explanation of the reason for the denial. *You* have the right to have your claim reviewed and reconsidered.

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

*We* agree to duly investigate and endeavor to resolve any and all complaints received from *members* with regard to the nature of professional services rendered. Any inquiries or complaints may be made to Guardian by writing or calling *us* at the address and telephone indicated in this booklet.







**GUARDIAN<sup>SM</sup>**

**The Guardian Life Insurance  
Company of America**

7 Hanover Square  
New York, New York 10004-2616

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