



GUARDIAN<sup>SM</sup>

**YOUR GROUP INSURANCE  
PLAN BENEFITS**

HEALTHPASS INSURANCE TRUST  
CLASS 3/OPTION J - SOLE PROPRIETORS 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.

---

**CERTIFICATE OF COVERAGE**

---

**The Guardian**

7 Hanover Square  
New York, New York 10004  
(888) 618-2016

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-MDG-NY1

B850.0560-R

---

## GENERAL PROVISIONS

---

---

### Definitions

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*.

---

### Limitation of Authority

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.

---

### Incontestability

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.

---

### Examination

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.

---

## MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

---

**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.)

---

- (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.)

---

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*.

CGP-MDG-ELIG-A-FCW

B850.1302-R

---

## YOUR CONTINUATION RIGHTS

---

*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.*

---

### An Important Notice About Continuation Rights

---

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.

---

### Federal Continuation Rights

---

**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.)

---

**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.)

---

**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*.

CGP-3-MDG-CC1

B850.1226-R

**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.)

---

- (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.

CGP-3-MDG-CC2

B850.0565-R

---

## DENTAL EXPENSE COVERAGE

---

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.

---

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

---

**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.)**

---

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.

CGP-3-MDG-DE-1-NY-FCW

B850.0566-R

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

---

**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.)**

---

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.

CGP-3-MDG-DE2BNY-FCW

B850.0568-R

### **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.*

CGP-3-MDG-EM

B850.0569-R

**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.)

---

- (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.

CGP-3-MDG-GRV-NY

B850.0570-R

**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.)

**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

B850.0575-R

**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*.

CGP-3-MDG-GRVNY2

B850.0571-R

---

## Utilization Review and Utilization Review Appeal Process

**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.)

---

"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.)

---

**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.

CGP-3-MDG-UR-NY

B850.0572-R

**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.)

---

**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.

CGP-3-MDG-UR-NY

B850.0573-R

**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.)

---

- (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

B850.0574-R

## 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.

CGP-3-MDG-L1-FCW

B850.0576-R

### 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.

CGP-3-MDG-L2-FCW

B850.0579-R

### 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

B850.0582-R

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.)

---

<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.

CGP-3-MDG-L4-NYA-FCW

B850.0585-R

## Additional Conditions On Covered Services

---

**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.)

---

- 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.
- CGP-3-MDG-GG-FCW B850.1304-R
- 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.)

---

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.

CGP-3-MDG-ORTH-A-FCW 11/00

B850.1305-R

### 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.)

- 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

B850.0591-R

---

## Exclusions

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.)

---

- 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.)

---

- 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

B850.0593-R

---

## GLOSSARY

---

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.)

---

<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

---

## COORDINATION OF BENEFITS

---

---

### Applicability

---

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.

---

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

---

*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.)

---

- (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.

---

## 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.)

---

- 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

---

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.

CGP-3-MDG-COB2-NY

B850.0619-R

---

## STATEMENT OF ERISA RIGHTS

---

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

- (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