
**YOUR
GROUP INSURANCE
PLAN**

**DAEMEN COLLEGE
CLASS 0001 0002 0003 0005
DENTAL**

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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

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.

B110.0023-R

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IMPORTANT NOTICE

SECTION I The benefits described in Section I of this booklet are directly funded through and provided by your employer, and are not insured by Guardian.

Your employer, has the sole responsibility and liability for payment of these benefits. Guardian supplies administrative services, such as: claims services and preparation of employee benefit booklets.

As used in Section I of this booklet, the terms:

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

All terms and provisions, maximums or limitations set forth in Section I of this Certificate Booklet will be applicable to the benefits described in Section I of this booklet and provided by your employer.

SECTION II These benefits are purchased and provided through a group insurance plan issued by Guardian to your employer.

B115.0127-R

SECTION I: Employer-Funded Benefits Not Insured By Guardian

B115.0002-R

An Important Notice About Continuation Rights

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

B235.0109-R

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

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

This section does not apply to any coverage for loss of income due to disability. This coverage can not be continued under this section.

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

If Your Group Health Benefits End If you are a qualified continuee and your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

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

Extra Continuation for Disabled Qualified Continuees If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability as described in "The Qualified Continuee's Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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

Federal Continuation Rights (Cont.)

Special Continuance for Retired Employees and their Dependents

If your group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the employer, you may elect to continue such benefits, provided that:

- (a) you are or become a retired employee on or before the date group health benefits end; and
- (b) you and your dependents were covered for group health benefits under this plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for your lifetime. After your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for you and your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If you die before the bankruptcy proceeding under Title 11 of the United States Code, your surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceedings. The continuation can last for your surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.

B235.0146-R

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

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

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

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

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

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

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

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

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

B235.0181-R

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 health benefits; (b) the payments he or she must make to continue such benefits; and (c) the times and manner in which such payments must be made.

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee's continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

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

The subsequent payments 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 payments are due will be given.

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

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

Grace in Payment A qualified continuee's 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 payment is timely if it is made within 31 days of the specified due date. If timely payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the requirement for the payment that must be made; unless your employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to your employer.

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;
- (5) the end of the period for which the last payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

B235.0190-R

Uniformed Services Continuation Rights

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

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

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

B235.0194-R

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002-R

Employee Coverage

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

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

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

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

B489.0123-R

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

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

If you are a *qualified retiree*, you can not be confined in a health care facility on the scheduled effective date of coverage. If you are confined on that date, we will postpone your coverage until the day after you are discharged. And you must also have met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

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

B489.0067-R

When Your Coverage Ends If you are an active *full-time employee*, your coverage ends on the last day of the month in which your active *full-time* service ends for any reason, other than disability. Such reasons include retirement (except for *qualified retirees*), layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

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

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

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

B489.0077-R

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

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

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

When Continuation Ends Coverage may continue until the earliest of the following:

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

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

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

B449.0727-R

Dependent Coverage

B200.0271-R

Eligible Dependents For Dependent Dental Benefits Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 19; and (c) your unmarried dependent children from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools.

Dependent Coverage (Cont.)

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

B489.0301-R

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

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

B489.0003-R

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

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

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

The child's coverage ends when yours does.

B449.0042-R

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

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

Dependent Coverage (Cont.)

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

B200.0749-R

When Dependent Coverage Starts

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

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

If you do this within the *enrollment period*, the coverage is scheduled to start on the later of the first of the month which coincides with or next follows the date you sign the enrollment form; and the date you become insured for employee coverage.

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

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

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

B489.0055-R

Exception

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

B200.0692-R

Dependent Coverage (Cont.)

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

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

B489.0027-R

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your coverage ends.

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

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

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

Dependent Coverage (Cont.)

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he or she marries, when a child covered as a student is no longer an active *full-time* student, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment. But, if a child who is enrolled as a *full-time* student must take a medical leave of absence from school due to sickness, his or her coverage may be continued. Such coverage may be continued for up to one year from the last day the child attended school, but not beyond the date coverage would otherwise end under this *plan* if he or she did not take the medical leave of absence; provided: (a) we receive a *doctor's* certification of the sickness which requires the leave of absence; (b) the group *plan* remains in force; and (c) all required premiums for the child's coverage continue to be paid.

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

B509.0032-R

CERTIFICATE AMENDMENT

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

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

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

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

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

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.

Certificate Amendment (Cont.)

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

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

- a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section; or
- b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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

B210.0016-R

DENTAL HIGHLIGHTS

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

- **Benefit Year Cash Deductible for Non-Orthodontic Services** . . . None

B497.0067-R

- **Payment Rates:**

For Group I Services	100%
For Group II Services	80%
For Group III Services	60%
For Group IV Services	50%

B497.0086-R

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

For Group I, II and III Services Up to \$1,000.00

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services Up to \$900.00

B497.0105-R

Group Enrollment Period A group enrollment period is held each year from July 1st to July 31st . During this period, you may elect to enroll in dental insurance under this *plan*. Coverage starts on the August 1st that next follows the date of enrollment. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

B497.1014-R

DENTAL EXPENSE INSURANCE

This insurance will pay many of your and your covered dependents' dental expenses. What we pay and the terms for payment are explained below.

B490.0036-R

DentalGuard Preferred- This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from facilities that are under contract with *Guardian's dental preferred provider organization (PPO)*, Which is call DentalGuard Preferred.

The dental PPO is made up of preferred providers in a covered person's geographic area. Use of the dental PPO is voluntary. A covered person may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This plan usually pays a higher level of benefits for covered treatment furnished by a preferred provider. Conversely, it usually pays less for covered treatments furnished by a non-preferred providers.

When an employee enrolls in this *plan*, he or she and his or her dependents receive a dental plan ID card and information about current preferred providers. A *covered person* must present his or her ID card when he or she uses a *preferred provider*. Most preferred providers prepare necessary claim forms for the *covered person*, and submit the forms to us. We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the preferred provider.

What we pay is based on all the terms of this *plan*. Please read this plan carefully for specific benefit levels, deductibles, payment rates and payment limits.

A covered person may call the Guardian at the number shown on his or her ID card should he or she have any questions about this plan.

B497.0377-R

Covered Charges

Covered charges are the charges listed in the fee schedule the contracted provider has agreed to accept as payment in full.

We only pay for covered charges incurred by a *covered person* while he's insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is prepared. A covered charge for any other *prosthetic device* is incurred on the date the master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the active *appliance* is first placed. All other covered charges are incurred on the date the services are furnished.

B497.0378-R

Pre-Treatment Review

When the expected cost of a proposed course of treatment is \$300.00 or more, the *covered person's dentist* must send us a treatment *plan* before he starts. This must be done on a form acceptable to The Guardian. The treatment *plan* must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. Dental X-rays, study models and whatever else we need to evaluate the treatment *plan* must be sent to us, too.

A treatment *plan* must always be sent to us before *orthodontic treatment* starts.

We review the treatment *plan* and estimate what we will pay. The estimate will be sent to the *covered person's dentist*. If we don't agree with a treatment *plan*, or if one is not sent in, we have the right to base our payments on treatment suited to the *covered person's* condition by accepted standards of dental practice.

Pre-treatment review is not a guarantee of what we will pay. It tells the *covered person* and his *dentist*, in advance, what we would pay for the covered dental services named in the treatment *plan*. But payment is conditioned on: (a) the work being done as proposed and while the *covered person* is insured; and (b) the deductible and payment limit provisions and all of the other terms of this *plan*.

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

B490.0039-R

Benefits From Other Sources

Other plans may furnish similar benefits, too. For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. If you are, we coordinate our benefits with the benefits from these other plans. We do this so no one gets more in benefits than the charges he incurs.

B497.0437-R

The Benefit Provision - Qualifying For Benefits

Group I, II And III Non-Orthodontic Services

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

All charges must be incurred while the *covered person* is insured. We limit what we pay each *benefit year* to \$1,000.00. What we pay is based on all of the terms of this *plan*.

B497.0488-R

Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services only for covered dependent children who are less than 19 years old when the active *appliance* is first placed.

The Benefit Provision - Qualifying For Benefits (Cont.)

We pay for Group IV covered charges at the applicable payment rate. Using the treatment plan, we calculate the total benefit we will pay. We divide this into equal payments, which we spread out over the shorter of two years or the proposed length of treatment.

We make the initial payment when the active *appliance* is first placed. We make further payments at the end of each subsequent three month period. But treatment must continue and the *covered person* must stay insured. And we limit what we pay during a covered person's lifetime to \$900.00. What we pay is based on all of the terms of this *plan*.

Orthodontic benefits won't be charged against the *benefit year* payment limit which applies to all other services.

B490.0161-R

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

Benefits for Group I Services are paid at a rate of 100%

Benefits for Group II Services are paid at a rate of 80%

Benefits for Group III Services are paid at a rate of 60%

Benefits for Group IV Services are paid at a rate of 50%

B497.0501-R

After This Insurance Ends

We won't pay for charges incurred after this insurance ends. But we pay for the following if all work is finished in the 31 days after this insurance ends: (a) a crown, bridge or cast restoration, if the tooth is prepared before the insurance ends; (b) any other *prosthetic device*, if the master impression is made before the insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the insurance ends.

Benefits for *orthodontic treatment* will only be paid to the end of the month in which the insurance ends. The final payment will be pro-rated.

B490.0045-R

Special Limitations

Penalty For Late Entrants We won't cover charges incurred by a late entrant for: (1) Group II services until 6 months from the date he is insured by this *plan*; (2) Group III services until 12 months from the date he is insured by this *plan*; and (3) *orthodontic treatment* done in the first 24 months he is insured by this *plan*. However, this limitation will not apply to covered charges due solely to an *injury* suffered while insured.

Charges not covered due to this provision are not considered covered dental services and cannot be used to satisfy this *plan's* deductibles.

Special Limitations (Cont.)

A late entrant is a person who: (1) becomes insured more than 31 days after he is eligible; or (2) becomes insured again, after his coverage lapsed because he did not make required payments.

B490.0046-R

Teeth Lost Before A Covered Person Became Insured By This Plan A *covered person* may have lost one or more teeth before he became insured by this *plan*. Except as explained below, we won't pay for a *prosthetic device* which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the *covered person* became insured by this *plan*.

If This Plan Replaces Another Plan This *plan* may be replacing another plan your *employer* had with some other insurer.

We don't want anyone to lose benefits when this happens. So we pay for certain charges incurred before this *plan* starts, if: (1) the *covered person* was insured by the old plan; and (2) the old plan would have paid for such charges. But this *plan* must start right after the old plan ends. And the covered person must be insured by this *plan* from the start.

We limit what we pay to the lesser of: (1) what the old plan would have paid; or (2) what we would otherwise pay. And we deduct any benefits actually paid by the old plan under any extension provision.

In the first *benefit year* of this *plan*, we also reduce this *plan's* deductibles by the amount of covered charges applied against the old plan's deductible. And, in the first *benefit year*, we charge benefits which were paid by the old plan against this *plan's* payment limits.

B490.0053-R

Exclusions

- We won't pay for:
 - Oral hygiene, plaque control or diet instruction.
 - Precision attachments.
- We won't pay for:
 - Treatment which does not meet accepted standards of dental practice.
 - Treatment which is experimental in nature.
- We won't pay for any *appliance* or *prosthetic device* used to:
 - Change vertical dimension.
 - Restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*.
 - Splint or stabilize teeth for periodontic reasons.
 - Replace tooth structure lost as a result of abrasion or attrition.
 - Treat disturbances of the temporomandibular joint.
- We won't pay for any service furnished for cosmetic reasons. This includes, but is not limited to:
 - Characterizing and personalizing *prosthetic devices*.
 - Making facings on *prosthetic devices* for any teeth in back of the second bicuspid.

Exclusions (Cont.)

- We won't pay for replacing an *appliance* or *prosthetic device* with a like appliance or device, unless:
 - It is at least five years old and can't be made usable.
 - It is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be fixed.
- We won't pay for:
 - Replacing a lost, stolen or missing *appliance* or *prosthetic device*.
 - Making a spare *appliance* or device.
- We won't pay for treatment needed due to:
 - An on-the-job or job-related injury.
 - A condition for which benefits are payable by Worker's Compensation or similar laws.
- We won't pay for treatment for which no charge is made. This usually means treatment furnished by:
 - The *covered person's employer*, labor union or similar group, in its dental or medical department or clinic.
 - A facility owned or run by any governmental body.
 - Any public program, except Medicaid, paid for or sponsored by any government body.

But if a charge is made and we are legally required to pay it, we will.

B490.0145-R

List of Covered Dental Services

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

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

B490.0048-R

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis And Fluoride Treatments Prophylaxis (limited to one treatment in any six consecutive month period) - Allowance includes examination, scaling and polishing. Topical application of fluoride (limited to *covered persons* under age 18 and limited to one treatment in any six consecutive month period) - Allowance includes examination and prophylaxis.

Group I - Preventive Dental Services (Cont.)

(Non-Orthodontic)

Space Maintainers (limited to covered persons under age 16 and limited to initial appliance only)
Allowance includes all adjustments in the first six months after installation:

- Fixed, unilateral, band or stainless steel crown type.
- Fixed, unilateral, cast type.
- Removal, bilateral type.

Fixed And Removable Appliances To Inhibit Thumbsucking and Other Harmful Habits - (limited to *covered persons* under age 16 and limited to initial appliance only) - Allowance includes all adjustments in the first six months after installation.

Diagnostic Services Allowance includes examination and diagnosis - x-rays.

- Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 36 consecutive month period).
- Bitewing films (limited to a maximum of four films in any six consecutive month period).
- Other intraoral periapical or occlusal films-single films.
- Extraoral superior or inferior maxillary film.
- Panoramic film, maxilla and mandible (limited to once in any 36 consecutive month period).

Dental Sealants Limited to the unrestored permanent molars of *covered persons* under age 16 and limited to one treatment in any 36 consecutive month period.

Office Visits And Examinations Initial or periodic oral examination (limited to one examination in any six consecutive month period).

Emergency palliative treatment and other non-routine, unscheduled visits.

B497.0139-R

Group II - Basic Dental Services

(Non-Orthodontic)

Office Visits And Examinations Diagnostic consultation with a dentist other than the one providing treatment (limited to one consultation for each dental specialty in any 12 consecutive month period) - We pay for this only if no other service is rendered during the visit.

Diagnostic Services Allowance includes examination and diagnosis.

- Diagnostic casts.
- Biopsy and examination of oral tissue.

Group II - Basic Dental Services (Cont.) (Non-Orthodontic)

Restorative Services Multiple restorations on one surface will be considered one restoration. Also see "Major Restorative Services".

- Amalgam restorations.
- Synthetic restorations: Silicate cement, Acrylic or plastic, and Composite resin.
- Crowns: Acrylic or plastic, without metal, and Stainless steel.
- Pins: Pin retention, exclusive of restorative material.
- Recementation: Inlay or onlay, Crown, and Bridge.

Endodontic Services Allowance includes routine x-rays and cultures, but excludes final restoration.

- Pulp capping, direct.
- Remineralization (Calcium Hydroxide), as a separate procedure.
- Vital pulpotomy.
- Apexification.
- Root canal therapy on non-vital (nerve-dead) teeth: Traditional therapy, and Medicated paste therapy, N2 Sargenti.
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures.

Periodontic Services Allowance includes the treatment plan, local anesthetics and post-surgical care.

- Gingivectomy or gingivoplasty, per quadrant.
- Gingivectomy, per tooth (fewer than 6 teeth).
- Sub-gingival curettage and root planing, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).
- Pedicle or free soft tissue grafts, including donor sites.
- Osseous surgery, including flap entry and closure, per quadrant.
- Osseous grafts, including flap entry, closure and donor sites.
- Muco-gingival surgery.
- Occlusal adjustment, not involving restorations and done in conjunction with periodontic surgery, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).

Oral Surgery Allowance includes routine x-rays, the treatment plan, local anesthetics and post-surgical care.

- Extractions:
 - Uncomplicated extraction, one or more teeth.
 - Surgical removal of erupted teeth, involving tissue flap and bone removal.
 - Surgical removal of impacted teeth.

Group II - Basic Dental Services (Cont.)
(Non-Orthodontic)

- Other Surgical Procedures**
- Alveolectomy, per quadrant.
 - Stomatoplasty with ridge extension, per arch.
 - Removal of mandibular tori, per quadrant.
 - Excision of hyperplastic tissue.
 - Excision of pericoronal gingiva, per tooth.
 - Removal of palatal torus.
 - Removal of cyst or tumor.
 - Incision and drainage of abscess.
 - Closure of oral fistula or maxillary sinus.
 - Reimplantation of tooth.
 - Frenectomy.
 - Suture of soft tissue injury.
 - Sialolithotomy for removal of salivary calculus.
 - Closure of salivary fistula.
 - Dilatation of salivary duct.
 - Sequestrectomy for osteomyelitis or bone abscess, superficial.
 - Maxillary sinusotomy for removal of tooth fragment or foreign body.

B490.0150-R

Prosthodontic Services Specialized techniques and characterization are not covered. Also see "Major Prosthodontic Services".

- Denture repairs, acrylic: Repairing dentures, no teeth damaged; Repairing dentures and replace one or more broken teeth; and Replacing one or more broken teeth, no other damage.
- Denture repairs, metal - Allowance based on the extent and nature of damage and on the type of materials involved.
- Denture duplication, jump case (limited to once per denture in any 36 consecutive month period).
- Denture reline (limited to once per denture in any 12 consecutive month period): Office reline; Cold cure; Laboratory reline.
- Denture adjustments (limited to adjustments by a dentist other than the one providing the denture, and adjustments are more than 6 months after the initial installation).
- Tissue conditioning (limited to a maximum of 2 treatments per arch in any 12 consecutive month period).
- Adding teeth to partial dentures to replace extracted natural teeth.
- Repairs to crowns and bridges - Allowance based on the extent and nature of damage and the type of materials involved.

- Other Services**
- General anesthesia in connection with surgical procedures only.
 - Injectable antibiotics needed solely for treatment of a dental condition.

B490.0152-R

Group III - Major Dental Services

(Non-Orthodontic)

Restorative Services Cast restorations and crowns are covered only when needed because of decay or *injury*, and only when the tooth cannot be restored with a routine filling material. Also see "Basic Restorative Services".

- Inlays.
- Onlays, in addition to inlay allowance.
- Crowns and Posts: Acrylic with metal. Porcelain, Porcelain with metal, Full cast metal (other than stainless steel), 3/4 cast metal (other than stainless steel), Cast post and core, in addition to crown (not a thimble coping), Steel post and composite or amalgam core, in addition to crown, and Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown.

Prosthetic Services Specialized technique and characterizations are not covered.

Services

- Fixed bridges - Each abutment and each pontic makes up a unit in a bridge.
- Bridge abutments - See inlays and crowns under "Major Restorative Services".
- Bridge Pontics: Cast metal, sanitary, Plastic or porcelain with metal, Slotted facing, and Slotted pontic.
- Simple stress breakers, per unit.
- Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.
- Dentures - Allowance includes all adjustments done by the *dentist* furnishing the denture in the first 6 months after installation.
 - Full dentures, upper or lower.
 - Partial dentures - Allowance includes base, all clasps, rests and teeth.
 - Upper, with two chrome clasps with rests, acrylic base.
 - Upper, with chrome palatal bar and clasps, acrylic base.
 - Lower, with two chrome clasps with rests, acrylic base.
 - Lower, with chrome lingual bar and clasps, acrylic base.
 - Stayplate base, upper or lower (anterior teeth only).

B490.0170-R

Group IV - Orthodontic Services

- Orthodontic Services**
- Any Group I, II or III service in connection with *orthodontic treatment*.
 - Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes routine x-rays, local anesthetics and post-surgical care.
 - Active *appliances* - All types - Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active *appliance*, and all related office visits including post-treatment stabilization.

B490.0052-R

THIS IS NOT INSURANCE

Discounts on Services Not Covered Due To Contractual Provisions If a covered person receives dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of our DentalGuard Preferred PPO network, even if such services are not covered by the plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions, such as dental implants.

B499.0085-R

THIS IS NOT INSURANCE

Discounts on Cosmetic Dental Services If a covered person receives any of the following dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO; such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of our DentalGuard Preferred PPO network.

The services are:

Cosmetic bleaching (external bleaching, per arch; in office or take home).

B499.0086-R

This Is Not Insurance

Discounts on Dental Services Not Covered By This Plan A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

- (a) he or she receives services or supplies from a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) network; and
- (b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.

B499.0087-R

THIS IS NOT INSURANCE

Discounts on Orthodontic Services If a covered person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred PPO network; such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

- Pre-orthodontic treatment visit;
- Limited orthodontic treatment;
- Interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- Comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- Periodic comprehensive orthodontic treatment visit(as part of a contract);
- Orthodontic retention, including fixed and removable initial appliances and related visits. Discounted fees are not available for:
- Incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- Retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- Extractions performed solely to facilitate orthodontic treatment;
- Orthognathic surgery and associated incremental charges;
- Replacement of lost or broken retainers.

B499.0089-R

Discounts on Dental Services Not Covered By This Plan

A covered person under this plan can receive discounts on cavity fighting products such as Xylitol. The discount is 25%.

The services and supplies are not covered by this plan. The covered person must pay the entire discounted fee directly to the supplier. A claim should not be filed.

When a person is no longer covered by this plan, access to the discounts ends.

B499.0083-R

COORDINATION OF BENEFITS

Important Notice This section applies to all group health benefits under this plan, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

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

Definitions

Allowable Expense This term means any necessary, reasonable, and customary item of health care expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is **not** an allowable expense. Examples of other expenses or services that are **not** allowable expenses are:

- (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.
- (2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
- (3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- (4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans.

Claim This term means a request that benefits of a plan be provided or paid.

Definitions (Cont.)

- Claim Determination Period** This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.
- Closed Panel Plan** This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- Coordination Of Benefits** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- Custodial Parent** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- Group-Type Contracts** This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.
- Hospital Indemnity Benefits** This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of \$200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; (6) medical benefits under group or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.
- This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of \$200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.
- This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.
- Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

Definitions (Cont.)

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

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

This Plan This term means the group health benefits provided under this group plan.

B550.0087-R

Order Of Benefit Determination

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

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

A plan that does not contain a coordination of benefits provision is always primary.

This Plan **always** pays secondary to any motor vehicle policy available to a covered person, including any medpay, PIP, No Fault or any plan or program which is required by law. All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

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

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

Child Covered Under More Than One Plan The order of benefit determination when a child is covered by more than one plan is:

Order Of Benefit Determination (Cont.)

- (1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
- (2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

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

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

Length Of Coverage The plan that covered the person longer is primary.

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

B550.0088-R

Effect On The Benefits Of This Plan

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

When This Plan Is Secondary When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

Effect On The Benefits Of This Plan (Cont.)

Closed Panel Plans If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

B550.0089-R

SUBROGATION AND RIGHT OF RECOVERY

Notice This section applies to any health care or loss of earnings benefits under this plan.

Purpose When a covered person has the right to recover amounts paid by this plan for health care or loss of earnings benefits, this plan also has certain rights. These are explained below.

Definitions As used in this section, the terms listed below have the meanings shown below:

- **Covered Person:** This term means any employee or dependent on whose behalf this plan pays health care or loss of earnings benefits. It includes the parent or guardian of any such covered employee or dependent who is a minor or incompetent.
- **Health Care:** This term means any: (a) major medical; (b) prescription drug; (c) dental; or (d) vision benefits.
- **Insurance Coverage:** This term means any insurance which provides coverage for: (a) medical expense payments; or (b) liability. This includes, but is not limited to: (i) uninsured motorist coverage; (ii) underinsured motorist coverage; (iii) personal umbrella coverage; (iv) medical payments coverage; (v) workers compensation coverage; (vi) no-fault automobile insurance coverage; or (vii) any first party insurance.
- **Third Party:** This term means any party actually, possibly, or potentially responsible for making any payment to a covered person due to the covered person's injury, sickness or condition. This term also means such party's: (a) the liability insurer; or (b) any insurance coverage. But, this term does not mean: (i) this plan; or (ii) the covered person.

Subrogation When this plan pays a benefit, it will immediately be subrogated to the covered person's rights of recovery from any third party to the full extent of benefits paid.

Recovery If a covered person receives a payment from any third party or insurance coverage due to an injury, sickness or condition, this plan has the right to recover from, and be repaid by, the covered person for all amounts this plan has paid and will pay due to that injury, sickness or condition, from such payment, up to and including the full amount he or she receives from any third party or insurance coverage.

Constructive Trust The covered person must serve as a constructive trustee over the funds that constitute payment from any third party or insurance coverage due to his or her injury, sickness or condition. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. If the covered person fails to hold such funds in trust, it will be deemed a breach of his or her fiduciary duty to the plan.

Subrogation And Right Of Recovery (Cont.)

- Lien Rights** This plan will have a lien to the extent of benefits this plan paid due to the covered person's injury, sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or otherwise, including from any insurance coverage, that a covered person receives due to his or her injury, sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by this plan. This includes, but is not limited to: (a) the covered person; (b) the covered person's representative or agent; (c) the third party; (d) the third party's insurer, representative or agent; and (e) any other source who holds such funds.
- First Priority Claim** This plan's recovery rights are a first priority claim against all third parties or insurance coverage and are to be paid to the plan before any other claim for the covered person's damages. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. This plan will be entitled to full repayment on a first dollar basis from any third party's or insurance coverage's payments, even if such payment to the plan will result in a recovery to the covered person which is not sufficient: (i) to make him or her whole; or (ii) to compensate him or her in part or in whole for the damages sustained. This plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue his or her damage claim.
- Applicable To All Settlements And Judgements** This plan is entitled to full recovery regardless of whether: (a) any liability for payment is admitted by a third party; or (b) the settlement or judgement received by the covered person identifies the benefits the plan paid. This plan is entitled to recover from any and all settlements or judgements, even those designated as: (i) pain and suffering; or (ii) non-economic damages only.
- Cooperation** The covered person must fully cooperate with this plan's efforts to recover the benefits it paid. He or she must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his or her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, sickness or condition sustained by him or her. He or she, and his or her agents, must provide all information requested by the plan or its representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as the plan or its representative may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against him or her.
- The covered person must do nothing: (a) to prejudice this plan's rights as described in this section; or (b) to prejudice the plan's ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this plan. Failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery obtained by the covered person may result in the termination of benefits or the instigation of legal action against him or her.

Subrogation And Right Of Recovery (Cont.)

The plan or its representative has the right to conduct an investigation regarding the injury, sickness or condition to identify any third party. The plan reserves the right to notify the third party and his or her agents of this plan's lien. Agents include, but are not limited to: (a) insurance companies; and (b) attorneys.

Interpretation In the event that any claim is made that any part of this section is ambiguous, or questions arise as to the meaning or intent of any of its terms, the plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this section.

Jurisdiction Any legal action or proceeding with respect to this section may be brought in any court of competent jurisdiction as the plan may choose. The covered person must submit to each such jurisdiction and waive whatever rights may correspond to him or her by reason of his or her present or future domicile.

B600.0012-R

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00324707-HC

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

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

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

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

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

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

B900.0118-R

Active Appliance means an *appliance* like braces, used in *orthodontic treatment* to move teeth.

B750.0192-R

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

B750.0193-R

Benefit Year with respect to this *plan's* dental expense insurance, means a 12 month period which starts on August 1st and ends on July 31st.

B750.0444-R

Close Relative means: (a) a *covered person's* spouse, children, parents, brothers and sisters; and (b) any other person who is part of a *covered person's* household. We don't pay for services and supplies furnished by *close relatives*.

B750.0195-R

Covered Person with respect to this *plan's* dental expense insurance, means an *employee* or any of his *covered dependents*.

B750.0196-R

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

B750.0198-R

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

B900.0003-R

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

B750.0015-R

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

B750.0006-R

Employer means DAEMEN COLLEGE .

B900.0051-R

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

B900.0004-R

Glossary (Cont.)

- Full-time** means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 25 hours per week), at his *employer's* place of business.
- B750.0230-R
- Initial Dependents** means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents*, but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents*.
- B900.0006-R
- Injury** with respect to this *plan's* dental expense insurance, means all damage to a *covered person's* mouth due to an accident, and all complications rising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *prosthetic devices* which results from chewing or biting food or other substances.
- B750.0199-R
- Newly Acquired Dependent** means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents*.
- B900.0008-R
- Orthodontic Treatment** means the movement of one or more teeth by the use of *active appliances*. It includes: (a) diagnostic services; (b) the treatment plan; (c) the fitting, making and placement of an *active appliance*; and (d) all related office visits, including post-treatment stabilization.
- B750.0201-R
- Plan** means the *Guardian* group *plan* purchased by your *employer*, except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.
- B900.0039-R
- Prosthetic Device** means a device which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, pontics and cast restorations.
- B750.0203-R
- Qualified Retirees** are covered as outlined in your company's benefit provisions. Please see your Plan Administrator for details.
- B750.0008-R

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

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

- **Name of Plan:**

Daemen College GROUP INSURANCE PLAN

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

Daemen College

Address: 4380 Main Street

Amherst NY 14426

Phone Number: (716)839-8504

- **IRS Employer Identification Number (EIN):** 16-0759798

- **Plan Number:** 503

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

same as above

Address: 4380 Main Street

Phone Number:

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

same as above

Address:

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

- **Date of End of Plan Year:** One day prior to August 1st.

- Contributions to the plan are provided by the Employer and the Employee.

- The following class or classes of full-time employees are eligible to apply for insurance:

All Eligible Employees

provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details).

B800.0047

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

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

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

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

B800.0094-R

The Guardian's Responsibilities

B800.0048-R

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

B800.0064-R

The Guardian is located at 7 Hanover Square, New York, New York 10004.

B800.0049-R

Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

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

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

Urgent Care Claims. Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.

Group Health Benefits Claims Procedure (Cont.)

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Post-Service Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Group Health Benefits Claims Procedure (Cont.)

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided(a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

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

Appeal of Adverse Benefit Determinations

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

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

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

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

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

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

B800.0081-R

Termination of This Group Plan

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

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

B800.0068-R

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com

