



GUARDIANSM

**YOUR GROUP INSURANCE
PLAN BENEFITS**

LANDRUM PROFESSIONAL EMPLOYER SERVICES, INC.

CLASS 0001

DENTAL BASE

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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

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.

The Guardian Life Insurance Company of America

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

CGP-3-R-STK-90-3

B110.0023

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IMPORTANT NOTICE

Should you have any questions regarding this insurance, you may contact
The Guardian Life Insurance Company at:

The Guardian Sales Office
1511 N. West Shore Blvd., Suite 600
Tampa, FL 33607
Telephone: (813) 472-6080
(800) 282-6908
Fax: (813) 472-6090

CGP-3-FLDISC-93

B120.0020

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0012

Limitation of Authority

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

CGP-3-R-LOA-90

B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-90

B160.0003

Dental Claims Provisions

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

Dental Claims Provisions (Cont.)

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

Proof of Loss We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

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

Payment of Benefits We'll pay all dental benefits to which you're entitled as soon as we receive written proof of loss.

We pay all dental benefits to you, if you're living. If you're not living, we have the right to pay all dental benefits to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services.

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

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

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

CGP-3-R-AHC-90

B160.0058

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87

B240.0064

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

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

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

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

CGP-3-R-COBRA-96-1

B235.0164

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

CGP-3-R-COBRA-96-2

B235.0075

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 an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Federal Continuation Rights (Cont.)

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

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

CGP-3-R-COBRA-96-3

B235.0178

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Federal Continuation Rights (Cont.)

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

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

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

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;

Federal Continuation Rights (Cont.)

- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

B235.0198

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.

CGP-3-R-COBRA-96-4

B235.0195

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Employee Coverage

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

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

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

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

CGP-3-EC-90-1.0

B489.0122

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

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

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

CGP-3-EC-90-2.0

B489.0070

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B489.0075

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.

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.

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

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

CGP-3-EC-90-3.0

B449.0727

Dependent Coverage

B200.0271

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are: (a) your legal spouse; and (b) your dependent children, until the end of the calendar year in which they reach age 26, regardless of student status, marital status, financial dependency, residence or employment, as long as the dependent is not eligible for employer-sponsored coverage under the child's own employer.

A dependent child who is not able to remain enrolled as a 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*.

CGP-3-DEP-90-2.0

B489.0324-R

Dependent Coverage (Cont.)

Adopted Children And Step-Children Your "unmarried dependent children" include your 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 your 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.

CGP-3-DEP-90-3.0

B264.0007

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.

If a claim submitted on behalf of the child is denied because the child has reached the limiting age, you must submit proof that: (a) the child's condition started before he or she reached this coverage's age limit; (b) the child 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) the child depends on you for most of his or her support and maintenance.

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B449.0039

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

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

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

CGP-3-DEP-90-5.0

B200.0749

Dependent Coverage (Cont.)

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.

CGP-3-DEP-90-6.0

B489.0055

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.

CGP-3-DEP-90-7.0

B200.0692

Coverage For Newborn Children We cover your newborn child, subject to the conditions below, for dependent benefits starting from the moment of birth.

We also cover a newborn child of an insured family member (other than your spouse) from the moment of birth until the earlier of: (a) the date you are no longer insured under this coverage; or (b) the end of eighteen months, starting from the moment of such child's birth.

Dependent Coverage (Cont.)

You must notify us of the birth of the child within 31 days after the birth; and we will notify you of any additional premium that is required. If you provide us notice of the birth of the child within 31 days of the date of birth, no premium will be charged for the first 31 days of coverage. If you do not provide this notice within that 31 day period, premium will be charged from the date of birth.

Coverage For Adopted Children

We cover your adopted child for dependent benefits from the date of adoption or the date of placement in your home for the purpose of adoption, whichever comes first. You must notify us of the intent to adopt a child. In the case of a newborn child to be adopted, we cover the child from the moment of birth but only if a written agreement to adopt such child has been entered into by you prior to the birth of the child. A copy of the agreement must be sent to us prior to the child's birth, or as soon thereafter as is reasonably possible.

Upon receipt of such notice or agreement, we will notify you of any additional premium required for such child's coverage. Premium, if any, will be charged from the date of adoption, or the date of placement for the purpose of adoption, whichever comes first. With respect to a newborn child to be adopted in accord with a written agreement, premium, if any, will be charged from the date of birth.

You have 31 days from the date of notification to pay the additional premium. The child's coverage will end if you don't pay the additional premium within 31 days. Coverage also ends if the child is ultimately not placed in your home.

We consider an adopted child, newborn or otherwise, to be a newborn child for purposes of benefits provided.

Coverage For Foster Children

We cover your foster child or other child in court-ordered temporary or other custody of you for dependent benefits starting from the date of placement in your home. You must give us written notice within 31 days of the date of placement.

We will then notify you of any additional premium you must pay. And, you must pay the additional premium, if any, within 31 days from the date of notification to pay the additional premium. Premium, if any, will be charged from the date of placement. The child's coverage will end if you do not pay the additional premium within that 31 day period. Coverage also ends when the foster child is no longer in the custody of you.

CGP-3-DEP-90-8.0

B489.0028

When Dependent Coverage Ends

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

Dependent Coverage (Cont.)

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

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

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child at the end of the calendar year in which the child attains this coverage's age limit, when he or she marries, 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.

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.

CGP-3-DEP-90-9.0

B489.0048-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;
- 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 part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

The Guardian Life Insurance Company of America

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

CGP-3-A-DMST-96-FL

B210.0032

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.

- **PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

For Group I Services None
For Group II and III Services \$50.00
for each covered person

- **Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services**

For Group I Services None
For Group II and III Services \$50.00
for each covered person

CGP-3-DENT-HL-90

B497.0070

- **Payment Rates for Services Furnished by a Preferred Provider:**

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

- **Payment Rates for Services Not Furnished by a Preferred Provider:**

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

CGP-3-DENT-HL-90-07-L

B497.1915

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

For Group I, II and III Services Up to \$1,500.00

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

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

Note: A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.

CGP-3-DENT-HL-90-07-L

B497.1998

Group Enrollment Period

A group enrollment period is held each year. The group enrollment period is a time period agreed to by your employer and us. During this period, you may elect to enroll in dental insurance under this *plan*. Coverage starts on the first day of the month that next follows the date of enrollment. You and your *eligible dependents* are not subject to late entrant penalties if you enroll during the group enrollment period.

CGP-3-DENT-HLTS-07-L

B497.2406

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.

CGP-3-DNTL-90-1-07-L

B497.2007

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 *dentists* and dental care facilities that belong to DentalGuard Preferred, a dental preferred provider organization (PPO).

This dental PPO is made up of preferred providers in a *covered person's* geographic area. A "dental preferred provider" is a dental practitioner or a dental facility that: (a) is a current member of DentalGuard Preferred; and (b) has a participatory agreement in force with us.

Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he chooses. And, he is free to change providers anytime. But, this *plan* usually pays more in benefits for covered treatment furnished by a dental preferred provider. Conversely, it usually pays less for covered treatment not furnished by a dental preferred provider (even if the treatment is ordered by a preferred provider).

When you enroll in this *plan*, you and your dependents get a dental *plan* ID card and information about current dental preferred providers. A *covered person* must present his ID card when he goes to 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.

What we pay is based on all the terms of this *plan*. Please read this material with care, and have it available when seeking dental care. Read this booklet carefully for specific benefit levels, deductibles, payment rates and payment limits.

You can call The Guardian Group Claim Office if you have any questions after reading this material.

CGP-3-DENT-PPO-A-07-L

B497.2010

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in the List of Covered Dental Services.

By reasonable, we mean the charge is the *dentist's* usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists*. But, in no event will the covered charge be greater than the 90th percentile of the HIAA Prevailing Fee, or a similar standard, for a particular service in a geographic area. When routinely associated procedures are performed on the same day, the covered charge will be for the most comprehensive procedure.

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. All other covered charges are incurred on the date the services are furnished.

CGP-3-DG3-CC-93

B497.0259

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice. In the case of bilateral multiple adjacent missing teeth, the benefit will be based on a removable partial denture.

Proof of Claim

In order to accurately pay for and determine covered charges, it is required that information acceptable to The Guardian be provided. This information shall consist of x-rays, study models, narratives or other diagnostic materials. If the necessary information is not provided, no benefit or minimum benefits may be allowable. However, if accepted necessary information is provided later, benefits will be redetermined based on the new information.

CGP-3-DG3-ALT-92

B497.0005

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.

Pre-Treatment Review (Cont.)

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.

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

CGP-3-DG3-PTR-92

B497.0262

Appeals of Adverse Determinations

If a *covered person* or *health care provider* does not agree with an *adverse determination*, the *covered person* or *health care provider* may submit an *appeal* as explained below.

The *covered person* or *health care provider* must file an *appeal* in writing concerning an *adverse determination*. The *appeal* should contain sufficient detail to identify the nature of the problem. Any documentation that the parties believe is relevant may be submitted to support an *appeal*.

The *appeal* should be directed to:

Group Quality Assurance - WRO
Guardian
P.O. Box 2457
Spokane, WA 99210-2457
FAX: 1-509-468-6399

The written *appeal* will be referred to a Group Quality Assurance Dental Review Specialist who will open a case file and conduct an investigation. In resolving an *appeal*, best efforts are made to obtain all relevant information, including clinical records.

The *health care provider* will be contacted and given the opportunity to respond to the *appeals*. If appropriate, the *health care provider* will be advised to submit copies of the patient's clinical records and any other pertinent dental information.

For dental care services under review, the *appeal* decision shall be made by a licensed dentist, or a panel of other appropriate health care providers with at least one licensed dentist on the panel.

An opinion will be forwarded in writing to all parties within 15 working days of the date that the *appeal* is received by *us*.

Definitions "Adverse determination" means a utilization review determination by a private review agent, Guardian, or a health care provider acting on behalf of Guardian that:

- a) a proposed or delivered dental care service which would otherwise be covered under the covered person's contract is not or was not medically necessary, appropriate, or efficient; or
- b) an alternate dental service is adequate and appropriate care in accordance with accepted dental standards; and
- c) may result in non-coverage of the dental service.

"Appeal" means a protest filed by a covered person, or dentist acting on behalf of a covered person, regarding an adverse determination concerning the covered person.

"Health care provider" means:

- a) an individual licensed to provide dental care services in the ordinary course of business or practice of a profession and is a treating provider of the covered person; and
- b) for purposes of this provision, is acting on behalf of the covered person.

CGP-3-APPEAL-FL-02-07-L

B497.2028

Benefits From Other Sources

This *plan* supplements the medical plan provided by your *employer*, if any.

This *plan*, and your *employer's* medical plan, if any, may provide benefits for the same charges. If they do, we subtract what your *employer's* medical plan, if any, pays from what we'd otherwise pay.

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. Read "Coordination of Benefits" to see how this works.

CGP-3-DNTL-90-5-07-L

B497.2027

Extended Dental Expense Benefits

If a *covered person's* insurance ends, we extend dental expense benefits for that *covered person* under this *plan* as explained below.

We only extend benefits for covered charges for dental procedures, if the procedures: (a) are in connection with a specific accident or illness incurred while the policy was in effect; (b) are recommended in writing and begun before the *covered person's* insurance ends; (c) are performed within 90 days after the date the *covered person's* insurance ends; and (d) are for other than routine examinations, prophylaxis, x-rays, sealants or orthodontic services.

Extended Dental Expense Benefits (Cont.)

The extension of benefits terminates upon the earlier of: (a) 90 days after the *covered person's* insurance ends; or (b) the date the *covered person* becomes covered under another plan providing coverage for similar dental procedures. However, if the succeeding plan excludes the above services through the use of an elimination period, then the extension of benefits will terminate 90 days after the *covered person's* insurance ends.

We don't grant an extension if the *covered person's* insurance was voluntarily terminated by the employee. And what we pay is based on all the terms of this *plan*.

CGP-3-DEXT-FL-94-07-L

B497.2029

The Benefit Provision - Qualifying For Benefits

Group I, II And III Non-Orthodontic Services

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

A *benefit year* deductible of \$50.00 applies to Group II and III services provided by a PPO Provider, and a *benefit year* deductible of \$50.00 applies to Group II and III services provided by a Non-PPO Provider. Each *benefit year*, each *covered person* must have *covered charges* from these service groups which exceed each applicable deductible before we pay him or her any benefits for such charges. These charges must be incurred while he or she is insured.

Covered charges used to satisfy a *covered person's* Non-PPO deductible are also credited toward his or her PPO deductible. And *covered charges* used to satisfy a *covered person's* PPO deductible are also credited toward his or her Non-PPO deductible.

Once a *covered person* meets his or her deductible, we pay for his or her Group II and III *covered charges* above that amount at the applicable payment rate for the rest of that *benefit year*. There are different payment rates which apply to *covered charges* for services from a PPO Provider and a Non-PPO Provider.

All charges must be incurred while the *covered person* is insured. We limit what we pay each *benefit year* to a PPO Provider to \$1,500.00. And we limit what we pay each *benefit year* to a Non-PPO Provider to \$1,000.00. What we pay is based on all of the terms of this *plan*.

Benefits applied to a *covered person's* Non-PPO *benefit year* payment limit are also applied to his PPO *benefit year* payment limit. And benefits applied to a *covered person's* PPO *benefit year* payment limit are also applied to his Non-PPO *benefit year* payment limit.

CGP-3-DNTL-92-7

B497.0648

The Benefit Provision - Qualifying For Benefits

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

CGP-3-DG-ROLL-04-2.1

B498.2041

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A *covered person* may be eligible for a rollover of a portion of his or her unused *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a *covered person* submits at least one claim for covered charges during a *benefit year* and, in that *benefit year*, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the *Rollover Threshold*, he or she may be entitled to a *Reward*.

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider*, he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider*.

Rewards can accrue and are stored in the *covered person's Bank*. If a *covered person* reaches his or her *benefit year* payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the *covered person's Bank*. The amount of *Reward* stored in the *Bank* may not be greater than the *Bank Maximum*.

A *covered person's Bank* may be eliminated, and the accrued *Reward* lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this *plan's Rollover Threshold, Reward, and Bank Maximum* are:

- *Rollover Threshold* \$500.00
- *Reward* (if all benefits are for services provided by a *preferred provider*) \$350.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider*) \$250.00
- *Bank Maximum* \$1,000.00

If this *plan's* dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full *benefit year*. And, if the effective date of a *covered person's* dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full *benefit year*. In either case:

- only claims incurred on or after January 1 will count toward the *Rollover Threshold*; and

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)

- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a *covered person* for a period set forth in the provision of this *plan* called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the *covered person* until the end of such period. And, if such period ends within the three months prior to the start of this plan's next *benefit year*, this rollover provision will not apply to the *covered person* until the next *benefit year*, and:

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover Threshold*; and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"*Bank*" means the amount of a *covered person's accrued Reward* .

"*Bank Maximum*" means the maximum amount of *Reward* that a *covered person* can store in his or her *Bank*.

"*Reward*" means the dollar amount which may be added to a *covered person's Bank* when he or she receives benefits in a *benefit year* that do not exceed the *Rollover Threshold*.

"*Rollover Threshold*" means the maximum amount of benefits that a *covered person* can receive during a *benefit year* and still be entitled to receive a *Reward*.

CGP-3-DG-ROLL-04-2

B498.2037

**Non-Orthodontic
Family Deductible
Limit**

No family must meet more than three *benefit year* deductibles in any *benefit year*. Once this happens, we pay for *covered charges* incurred by any covered person, at the applicable payment rate, for the rest of that *benefit year*. But the charges must be incurred while insured. And what we pay is subject to the *benefit year* payment limit and to all of the other terms of this *plan*.

CGP-3-DNTL-90-9

B497.0265

Payment Rates

Benefits for covered charges are paid at the following rates:

Benefits for Group I Services performed by
a preferred provider are paid at a rate of 100%

Benefits for Group I Services performed by
other providers are paid at a rate of 100%

Benefits for Group II Services performed by
a preferred provider are paid at a rate of 80%

The Benefit Provision - Qualifying For Benefits (Cont.)

Benefits for Group II Services performed by other providers are paid at a rate of 80%

Benefits for Group III Services performed by a preferred provider are paid at a rate of 50%

Benefits for Group III Services performed by other providers are paid at a rate of 50%

CGP-3-DRATE-90-07-L

B497.2130

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.

CGP-3-DNTL-90-10

B497.0269

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*; and (2) Group III services until 12 months from the date 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.

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.

CGP-3-DNTL-90-11.0

B497.0271

Teeth Lost Or Missing Before A Covered Person Becomes Insured By This Plan A *covered person* may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this *plan*. 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.

Special Limitations (Cont.)

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.

CGP-3-DG3-SL-93

B497.0273

Exclusions

- We won't pay for:
 - Oral hygiene, plaque control or diet instruction.
 - Precision attachments.
 - Desensitizing medicaments.
 - Prescription medication.
- 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 *orthodontic treatment*, unless the Benefit Provision provides specific benefits for this.
- 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.
- 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.
- We won't pay for replacing an *appliance* or *prosthetic device* or processed veneer with a like appliance or device, unless:
 - It is at least ten 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 made serviceable.
- We won't pay for:
 - Replacing a lost, stolen or missing *appliance* or *prosthetic device*.
 - Making a spare *appliance* or device.

Exclusions (Cont.)

- We won't pay for:
 - Implants.
 - Tooth transplants.
 - Surgical repositioning of the jaw.
 - We won't pay for treatment needed due to 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.
- We won't pay for overdentures.

CGP-3-XCL-FL-94

B497.0352

List of Covered Dental Services

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

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

CGP-3-DNTL-90-13-07-L

B497.2155

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis And Fluoride Treatments Prophylaxis, including periodontal prophylaxis (Topical application of fluoride is limited to *covered persons* under age 14 and limited to one treatment in any six consecutive month period) - Allowance includes examination, scaling and polishing.

Office Visits And Examinations Initial or periodic oral examination (limited to one examination in any 6 consecutive month period).

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

CGP-3-DNTL-90-14

B497.0983

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 - (limited to covered persons under age 14 and limited to initial appliance only) - Allowance includes all adjustments in the first 6 months after installation.

CGP-3-DNTL-90-14

B497.0298

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 60 consecutive month period).
 - Bitewing films (limited to a maximum of four films in one visit, in any 12 consecutive month period).
 - Other intraoral periapical or occlusal films - single films (limited to 4 periapical & 2 occlusal in any 12 consecutive month period).
 - Extraoral superior or inferior maxillary film (limited to 2 in any 12 consecutive month period).
 - Panoramic film, maxilla and mandible (only for treatment of accidents, cysts & tumors).

CGP-3-DNTL-90-14

B497.0761

Dental Sealants Posterior Teeth

- Topical application of sealant (limited to the unrestored permanent molar teeth of *covered persons* under age 16 and limited to one treatment per tooth in any 36 consecutive month period).

CGP-3-DNTL-90-14

B497.0981

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 examinations and diagnosis.

- Diagnostic casts - complex restorative cases only.
- 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: Stainless steel.
- Pins: Pin retention, exclusive of restorative material.

CGP-3-DNTL-90-15.0

B497.0306

- 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.

CGP-3-DNTL-90-15.0

B497.0312

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

- Adding teeth to partial dentures to replace extracted natural teeth.
- Repairs to crowns - allowance based on the extent and nature of damage and the type of material involved.

Other Services

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

CGP-3-DNTL-90-15.1

B497.0315

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.

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

- 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.
 - Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown.
 - Acrylic or plastic, without metal.
 - Crown buildup.
 - Labial veneers.
- Recementation
 - Inlay or onlay.
 - Crown.
 - Bridge.

Prosthodontic Service Specialized technique and characterizations are not covered.

- 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.
 - 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).
- Denture repairs, acrylic
 - Repairing dentures, no teeth damaged.
 - Repairing dentures and replace one or more broken teeth.
 - 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.

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

- Denture duplication, jump case (limited to once per denture in any 60 consecutive month period).
- Denture reline (limited to once per denture in any 24 consecutive month period):
 - Office reline.
 - Laboratory reline.
- Denture adjustments (limited to adjustments made 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 24 consecutive month period).
- Repairs to bridges - allowance based on the extent and nature of damage and the type of materials involved).

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.

CGP-3-DNTL-90-16

B497.0316

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

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

CGP-3-DNTL-90-16

B497.0318

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

- Gingivectomy or gingivoplasty, per quadrant (limited to once in 36 months on a given area.)
- 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.

Group III - Major Dental Services (Cont.)
(Non-Orthodontic)

- Osseous surgery, including flap entry and closure, per quadrant (once every 3 years).
- 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 36 consecutive month period).

CGP-3-DNTL-90-16

B497.0319

DISCOUNT - 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.

B499.0077

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.

B499.0079

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.

B499.0081

CERTIFICATE AMENDMENT

The certificate is amended as follows:

The Dental Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

- (a) your dependent child is a child under age 26;
- (b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);
- (c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and
- (d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

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

CGP-A-1

B531.0099

COORDINATION OF BENEFITS

Important Notice This section applies to all group dental benefits under this plan. 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 dental 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) 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 preferred provider arrangements.
- (2) 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.
- (3) 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. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

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

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.

Definitions (Cont.)

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 dental care or treatment: (1) group hospital, medical or surgical expense insurance; (2) group health care services plans; (3) group-type self-insurance plans; and (4) governmental benefits, as permitted by law.

This term does not include: (a) individual or family insurance; (b) school accident type coverage; (c) indemnity-type policies, excess insurance coverage, health benefit policies limiting coverage to specified illnesses or accidents; or (d) 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.

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, dental benefits provided under this group plan.

CGP-3-R-COB-05

B555.0358

Order Of Benefit Determination

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

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

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

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the 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.

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

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

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

Order Of Benefit Determination (Cont.)

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.

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.

Right To Receive And Release Needed Information

Certain facts about dental 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.

CGP-3-R-COB-05

B555.0359

GLOSSARY

	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
Appliance	means any dental device other than a <i>prosthetic device</i> .	
	CGP-3-GLOSS-90	B750.0193
Benefit Year	with respect to this <i>plan's</i> dental expense insurance, means a 12 month period which starts on January 1st and ends on December 31st of each year.	
	CGP-3-GLOSS-90	B750.0293
Close Relative	means: (a) a <i>covered person's</i> spouse, children, parents, brothers and sisters; and (b) any other person who is part of a <i>covered person's</i> household. We don't pay for services and supplies furnished by <i>close relatives</i> .	
	CGP-3-GLOSS-90	B750.0195
Covered Person	with respect to this <i>plan's</i> dental expense insurance, means an <i>employee</i> or any of his <i>covered dependents</i> .	
	CGP-3-GLOSS-90	B750.0196
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 <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0198
Eligibility Date	for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.	
	CGP-3-GLOSS-90	B900.0003
Eligible Dependent	is defined in the provision entitled "Dependent Coverage."	
	CGP-3-GLOSS-90	B750.0015
Employee	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	
	CGP-3-GLOSS-90	B750.0006
Employer	means LANDRUM PROFESSIONAL EMPLOYER SERVICES, INC. .	
	CGP-3-GLOSS-90	B900.0051
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.	
	CGP-3-GLOSS-90	B900.0004
Full-time	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 30 hours per week), at his <i>employer's</i> place of business.	
	CGP-3-GLOSS-90	B750.0229

Glossary (Cont.)

Initial Dependents	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee coverage</i> . If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0006
Injury	means all damage to a covered person's mouth due to an accident, and all complications rising from that damage.	CGP-3-GLOSS-90	B750.0300
Newly Acquired Dependent	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0008
Orthodontic Treatment	means the movement of one or more teeth by the use of <i>active appliances</i> . It includes: (a) diagnostic services; (b) the treatment plan; (c) the fitting, making and placement of an <i>active appliance</i> ; and (d) all related office visits, including post-treatment stabilization. This <i>plan</i> does not pay for <i>orthodontic treatment</i> .	CGP-3-GLOSS-90	B750.0202
Plan	means the <i>Guardian</i> group <i>plan</i> purchased by your <i>employer</i> , except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.	CGP-3-GLOSS-90	B900.0039
Prosthetic Device	means a restorative service which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, veneers, pontics and cast restorations.	CGP-3-GLOSS-90	B750.0294

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.

The Guardian's Responsibilities

CGP-3

B800.0048

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

CGP-3

B800.0053

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

CGP-3

B800.0049

Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

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

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

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;

Group Health Benefits Claims Procedure (Cont.)

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

CGP-3-ERISA

B800.0076

Termination of This Group Plan

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

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

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

CGP-3

B800.0086

NOTICE OF PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.**

Effective: 9/23/2013

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.GuardianLife.com/PrivacyPolicy

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and LTC coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information

about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0046

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. A breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding(e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- Guardian may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an

inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).

- We may disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0047

Your Rights with Regard to Your Protected Health Information (PHI): Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation,(ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An 'accounting of disclosures' is a list of the disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing. Your request must state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list(e.g., paper, electronically).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply(except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0048

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it(ii) if we do not maintain the PHI at issue(iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457

B998.0049



GUARDIANSM

**The Guardian Life Insurance
Company of America**

7 Hanover Square
New York, New York 10004-2616

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