



GUARDIANSM

**YOUR GROUP INSURANCE
PLAN BENEFITS**

**BROOKLYN ALLIANCE, INC. DBA BROOKLYN HEALTHWORKS
C/O BROOKLYN CHAMBER OF COMMERCE
MANAGED DENTALGUARD**

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.



Vice President, Group Products

CGP-3-R-STK-90-3

B110.0023

TABLE OF CONTENTS

SECTION I: Non-Managed DentalGuard Insurance	1
GENERAL PROVISIONS	
Limitation of Authority	3
Incontestability	3
Accident and Health Claims Provisions	4
An Important Notice About Continuation Rights	5
YOUR CONTINUATION RIGHTS	
Federal Continuation Rights	6
Uniformed Services Continuation Rights	10
ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE	
Employee Vision Coverage	11
Your Right To Continue Group Coverage During A Family Leave Of Absence	12
Dependent Vision Coverage	13
Dependent Vision Care Expense Coverage	13
VISION CARE HIGHLIGHTS	17
VISION CARE BENEFITS	
This Plan's Vision Care Preferred Provider Organization	18
Appeals Process	19
Grievance Process	19
Internal Grievance Procedure	21
External Grievance Procedure	22
How This Plan Works	23
Exclusions	27
REQUIRED DISCLOSURE STATEMENT	28
GLOSSARY	29
STATEMENT OF ERISA RIGHTS	
The Guardian's Responsibilities	34
Group Health Benefits Claims Procedure	35
Termination of This Group Plan	39
SECTION II: Managed DentalGuard Expense Plan	41

SECTION I: Non-Managed DentalGuard Insurance

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

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

B850.0181

GENERAL PROVISIONS

As used in this booklet:

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

"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

B160.0002

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 made by a person insured under this *plan* shall be used in contesting the validity of his or her insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his or her lifetime. The application must be signed by the covered person and a copy furnished to him or her or his or her beneficiary.

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-NY-01

B160.0106

Accident and Health Claims Provisions

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

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

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

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

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

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

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

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

CGP-3-R-AHC-90

B160.0005

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.

Under federal law, "marriage" means a legal union between one man and one woman as husband and wife, and "spouse" refers to a person of the opposite sex who is a husband or wife. This plan will allow an active, covered employee's spouse of the same sex and that spouse's dependent children to continue group health benefits under this provision only when: (a) the employer consents; and (b) that employee elects such continuation coverage.

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.

Federal Continuation Rights (Cont.)

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

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

An additional 50% of the total 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

B235.0294

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.

Federal Continuation Rights (Cont.)

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.

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.

Federal Continuation Rights (Cont.)

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.

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;

Federal Continuation Rights (Cont.)

- (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;
- (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 VISION CARE EXPENSE COVERAGE

B505.0152

Employee Vision Coverage

Your eligibility for vision care coverage under this *plan* is contingent upon your eligibility for dental coverage under this *plan*.

If you are covered for dental coverage under this *plan*, you are eligible for vision coverage under this *plan*.

If you are not covered under this *plan's* dental coverage, you are not eligible to be covered under this *plan's* vision coverage.

Your vision coverage under this *plan* starts on the later of: (a) the effective date of this *plan*; or (b) the date you become covered for dental benefits under this *plan*.

Your vision coverage under this *plan* ends on the earlier of: (a) the date this *plan* ends; or (b) the date you are no longer covered for dental benefits under this *plan*.

CGP-3-EC-90-1.0

B505.0158

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But you must be actively at work on a *full-time* basis on that 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 that date, we will postpone your coverage until the date you return to active *full-time* work.

Sometimes, the effective date shown on the sticker is not a regularly scheduled work day. But your coverage will still start on that date if you were actively at work on your last regularly scheduled work day.

CGP-3-EC-90-2.0

B505.0075

When Your Coverage Ends

Your coverage under this *plan* ends on the last day of the month in which your active *full-time* service ends for any reason. Such reasons include disability, 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 part of the cost of this *plan* 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 vision care benefits for a limited time.

CGP-3-EC-90-3.0

B505.0083

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.
- **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.

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

- **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 Vision Coverage

Your covered dependent's eligibility for vision care coverage under this *plan* is contingent upon his or her eligibility for dental coverage under this *plan*.

If a dependent is covered for dental coverage under this *plan*, he or she is eligible for vision coverage under this *plan*.

If the dependent is not covered under this *plan's* dental coverage, the dependent is not eligible to be covered under this *plan's* vision coverage.

The dependent's vision coverage under this *plan* starts on the later of: (a) the effective date of this *plan*; or (b) the date the dependent becomes covered for dental benefits under this *plan*.

The dependent's vision coverage under this *plan* ends on the earlier of: (a) the date this *plan* ends; or (b) the date he or she is no longer covered for dental benefits under this *plan*.

CGP-3-DEP-90-1.0

B505.0156

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 20; and (c) your unmarried dependent children from age 20 until their 26 birthday, who are enrolled as full-time students at accredited schools.

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

CGP-3-DEP-90-2.0

B505.0782

**Adopted Children
And Step-Children**

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

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-91-3.0-NY

B505.0115

**Handicapped
Children**

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B505.0119

**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 all of your initial *dependents* and agree to make any required payments.

If you do this on or before your *eligibility date*, date, your dependent coverage is scheduled to start on the later of the date you sign the enrollment form and the date you become covered for employee coverage.

If you do this within 31 days of your *eligibility date*, date, your dependent coverage is scheduled to start on the date you become covered for employee coverage.

If you do this after the enrollment *period* ends, you can't enroll your initial *dependents* until the next vision open enrollment period.

Once you have coverage for your initial *dependents*, you must notify us when you acquire any new dependents, and agree to make any additional payments required for the 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 becomes eligible. If you fail to notify us on time, you can't enroll the newly *acquired dependent* until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can't be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can't be enrolled again until the next vision open enrollment period.

CGP-3-DEP-90-6.0

B505.0714

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

B505.0132

Newborn Children We cover your newborn child from the moment of birth if you're already insured for dependent vision coverage, and you notify us within 31 days of the child's birth. If you fail to notify us on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is your first *eligible dependent*, we cover the child from the moment of birth if you enroll for dependent coverage and agree to make any required payments within 31 days of the child's birth. If you fail to enroll on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is not your first *eligible dependent*, but you did not previously enroll your other *eligible dependents* for vision care expense coverage, you can enroll the child during the next vision open enrollment period, if you also enroll all of your other *eligible dependents* at this time.

CGP-3-DEP-90-8.0

B505.0153

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your *employee* coverage ends. But if you die while insured, we'll automatically continue dependent vision care benefits for those of your dependents who are insured when you die. 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.

If a surviving dependent elects to continue his dependent vision care 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 Vision Care Expense Coverage (Cont.)

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

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

CGP-3-DEP-90-9.0

B505.0756

VISION CARE HIGHLIGHTS

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

PPO Copayments	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Contact Lenses	\$25.00
Non-PPO Cash Deductibles	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Contact Lenses	\$25.00

CGP-3-VSN-96-BEN3

B505.0519

If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan's materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.

B505.0516

VISION CARE BENEFITS

This insurance will pay many of an *employee's* and his or her covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

CGP-3-DAVIS-05-VIS

B505.0466

This Plan's Vision Care Preferred Provider Organization

Davis Vision: This *plan* is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Davis Vision's *Preferred Provider Network*.

This vision care *preferred provider* organization (PPO) is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from either a *preferred provider* or a *non-preferred provider*. And, he or she is free to change providers at any time. But, this *plan* usually pays more in benefits for covered services furnished by a vision care *preferred provider*. Conversely, it usually pays less for covered services not furnished by a vision care *preferred provider*.

When an *employee* and his or her *dependents* enroll in this *plan*, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *preferred providers*.

What we pay is based on all of the terms of this *plan*. The *covered person* should read this material with care and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, frequencies, *copayments* and payment limits.

The *covered person* can call Davis Vision if he or she has any questions after reading this material.

Choice of Preferred Providers When a person becomes enrolled in this *plan*, he or she will receive information about Davis Vision *preferred providers* in his or her area. A *covered person* may receive vision services from any current Davis Vision *preferred provider*.

When a *covered person* wants to receive services from a *preferred provider*, he or she must contact the *preferred provider* before receiving treatment. The *preferred provider* will contact Davis Vision to verify the *covered person's* eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a *preferred provider*.

This Plan's Vision Care Preferred Provider Organization (Cont.)

Non-Preferred Providers If a *covered person* receives services or supplies from a *non-preferred provider*, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received. Failure to furnish written proof within 90 days will not invalidate or reduce a claim if it will be shown not to have been reasonably possible to furnish such proof within such time frame, provided such proof was furnished as soon as reasonably possible.

Claims for services or supplies from a *non-preferred provider* must be sent to:

Davis Vision
159 Express Street
Plainview NY 11803
Attention: Quality Assurance/Patient Advocate Department.

CGP-3-DAVIS-05-PPOA-NY

B505.0531

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the *covered person's* vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, *covered person* or patient may appeal denied authorizations or claim decisions. Should a *covered person* request a review of an authorization or claim decision, Davis Vision must notify the *covered person*, or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the *covered person* or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision's Grievance Resolution Process or as per plan contract. A *covered person* has the right to appeal through an external review organization at any time during the grievance process. A *covered person* has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the *covered person's* legal rights.

Grievance Process

Registering a Complaint or Grievance A *covered person* has the right to file a grievance or make an appeal to any claim decision at any time. The *covered person* has the right to designate a representative to file complaints and appeals on his or her behalf.

A *covered person* is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a *covered person* should the determination be made that vision care benefits are not available.

Grievance Process (Cont.)

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:

1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

A grievance or complaint can arise from and includes but is not limited to the following:

1. benefit denials.
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract.
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services.
4. challenges with vision care services or products received.
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication

A *covered person* may file a verbal grievance by contacting Davis Vision. Registering a grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the grievance or appeal is received.

A *covered person* has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact their Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: **1 (800) 584-1487**.

Written Grievances

Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

**Davis Vision
159 Express Street
Plainview, New York 11803
Attention: Quality Assurance/Patient Advocate Department**

A *covered person* can register any concern or grievance by logging on to Davis' website: www.davisvision.com and entering the "Contact Davis Vision" area.

Internal Grievance Procedure

Appeal Level 1 Upon receipt of a concern or grievance by a Davis Vision associate, the *covered person* is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the *covered person* or his or her designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the *covered person* and may request additional information. Details of the complaint are documented in the *covered person's* file. The *covered person* is given the Associate's name, phone number, department and the estimated time needed to perform the research. The *covered person* is informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the *covered person* when further information is required and inform them of the status of the investigation or the need for more information.

B505.0470

The determination will be communicated to the *covered person* within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the *covered person* within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the *covered person* to Davis Vision within fifteen (15) business days of the date of notice of the decision.

Internal Grievance Procedure (Cont.)

Appeal Level 2 Should Davis Vision uphold a denial, as the result of a Level 1 review, the *covered person* has the right to request a Level 2 appeal.

A Level 2 appeal will not include associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the *covered person* to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The *covered person* requesting a Level 2 appeal must indicate the reason they believe the denial of coverage was incorrect. Davis Vision reserves the right to request further information from the *covered person* or provider.

Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 pre-service review. Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision Associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination the *covered person* will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

External Grievance Procedure

External Review A *covered person*, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A *covered person* who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

External Grievance Procedure (Cont.)

External Review Process A *covered person* has the right to an external review of a denial of coverage. A *covered person* has the right to an external review of a final adverse decision under the following circumstances:

- the *covered person* has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the *covered person* has been denied and any alternative service or treatment will not affect the *Covered person's* ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.
- the denied service, procedure or treatment is a covered benefit under the *Covered person's* policy.
- the *covered person* has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the *covered person* and the subsequent diagnostic findings could alter the *covered person's* treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.

CGP-3-DAVIS-05-APP-2

B505.0471

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. What we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

Covered charges are the *usual* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

CGP-3-DAVIS-05-HPW

B505.0472

How This Plan Works (Cont.)

Copays A *covered person* must pay a copay each time he or she receives a vision examination. A *covered person* must pay a copay each time he or she receives any vision materials covered by this *plan*.

CGP-3-DAVIS-05-COP

B505.0474

How We Cover Vision Examinations A *covered person* must pay a \$10.00 copay each time he or she receives a vision examination. If the vision examination is performed by a *preferred provider*, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a *non-preferred provider*, we pay benefits in excess of the copay up to \$46.00.

We pay benefits for one vision examination in any 12 month period.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

CGP-3-DAVIS-05-VE

B505.0478

How We Cover Vision Materials We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or *lenticular lenses*. We pay benefits for frames. We pay benefits for prescription contact lenses and a contact lens exam needed to check for eye health risks associated with improper wearing or fitting of contacts.

In any 12 month period we pay benefits for either glasses or contact lenses, but not both.

CGP-3-DAVIS-05-VM

B505.0480

How This Plan Works (Cont.)

How We Cover Standard Lenses

A *covered person* must pay a \$25.00 copay each time he or she purchases *standard lenses*. If the lenses are received from a *preferred provider*, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a *non-preferred provider*, we pay benefits in excess of the copay up to:

- \$47.00 for single vision lenses;
- \$66.00 for bifocal lenses;
- \$85.00 for trifocal lenses; and
- \$125.00 for *lenticular lenses*.

We cover one pair of *standard lenses* in any 24 month period.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras;

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses;
- glass-grey #3 prescription sunglasses;
- standard progressive addition lenses;
- photochromatic lenses - single vision or multifocal;
- ultra violet coating;
- blended invisible bifocal lenses;
- intermediate Lenses;
- supershield (scratchguard) coating.

The following cosmetic lens extras are not covered. But if a *covered person* purchases his or her lenses from a *preferred provider*, the price will be discounted as follows:

- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - \$90
- scratch resistant coating - single vision or multifocal - \$20
- plastic photosensitive lenses - \$65
- polarized lenses - \$75
- hi-Index lenses - \$55
- glare resistant treatment (multi layer hydrophobic) - \$35
- premium glare resistant treatment - \$48

CGP-3-DAVIS-05-SL

B505.0486

How We Cover Elective Contact Lenses

We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of *standard lenses* and frames.

How This Plan Works (Cont.)

If we cover charges for elective contact lenses, we will not cover charges for *standard lenses* and frames for at least 24 months.

A *covered person* must pay a \$25.00 copay each time he or she purchases elective contact lenses. If the contact lenses are purchased from a *preferred provider*, we pay benefits in full for the contact lenses in excess of the copay.

If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the copay up to a maximum of \$105.00.

CGP-3-DAVIS-05-ECL

B505.0487

How We Cover Necessary Contact Lenses

We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of *keratoconus*; and
- the *covered person* complies with the following requirements regarding prior notification.

The *covered person* or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of *keratoconus* before the lenses are dispensed. If the required notification is not obtained, benefits will be reduced by 50% for such lenses.

A *covered person* must pay a \$25.00 *copay* each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a *preferred provider*, we pay benefits in full for the lenses in excess of the *copay*. If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the *copay* up to a maximum of \$210.00.

*At Wal-Mart locations, members will receive Wal-Mart's every day low price on frame and contact lens purchase.

CGP-3-DAVIS-05-NCL-NY

B505.0535

How We Cover Frames

A *covered person* must pay a \$25.00 copay each time he or she purchases a set of frames.

If the frames are purchased from a *non-preferred provider*, we pay benefits in excess of the copay up to \$47.00.

If the frames are purchased from a *preferred provider*, we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' Tower designer frame collection (the Tower), we cover any frame selected from the Tower in full in excess of the copay.
- We cover a non-Tower frame in excess of the copay up to the retail allowance of \$135.00.

We cover one pair of frames in any 24 month period.

CGP-3-DAVIS-05-FRM

B505.0491

Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental training.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for treatment needed due to a condition for which benefits are payable by any state or Federal workers' compensation, employers' liability or occupational disease law.
- We won't pay for *plano lenses* (lenses with less than a .38 diopter power), unless medically necessary.
- We won't pay for two sets of glasses in lieu of bifocals.
- We won't pay for replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.

CGP-3-DAVIS-05-EXC-NY

B505.0536

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00452746-

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

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

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

Vision Expense Insurance (defined as Limited Benefits Health Insurance by the New York State Insurance Department)

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

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

GLOSSARY

	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
Blended Lenses	means bifocals which do not have a visible dividing line.	
	CGP-3-GLOSS-90	B750.0781
Coated Lenses	means substance added to a finished lens on one or both surfaces.	
	CGP-3-GLOSS-90	B750.0782
Copay	means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a <i>covered person</i> before any benefits are paid by this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0783
Covered Person	with respect to vision care insurance means an <i>employee</i> or <i>eligible dependent</i> who meets this <i>plan's</i> eligibility criteria and who is covered under this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0784
Customary	means, when referring to a covered charge, that the charge for the covered vision condition is not more than the <i>usual</i> charge made by most other doctors with similar training and experience in the same geographic area.	
	CGP-3-GLOSS-90	B750.0785
Deductible	with respect to Vision Care Insurance, means any amount which a <i>covered person</i> must pay before he or she is reimbursed for covered services provided by a <i>non-preferred provider</i> .	
	CGP-3-VSN-96-DEF3	B750.0483
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 BROOKLYN ALLIANCE, INC. DBA BROOKLYN HEALTHWORKS C/O BROOKLYN CHAMBER OF COMMERCE .	
	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

Glossary (Cont.)

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 20 hours per week), at his <i>employer's</i> place of business.	CGP-3-GLOSS.1	B750.0230
Initial Dependents	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee</i> coverage. 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
Keratoconus	means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.	CGP-3-GLOSS-90	B750.0786
Lenticular Lenses	means high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.	CGP-3-GLOSS-90	B750.0787
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
Non-Preferred Provider	with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the <i>covered persons</i> of the <i>plan</i> .	CGP-3-GLOSS-90	B750.0788
Orthoptics	means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	CGP-3-GLOSS-90	B750.0789
Oversize Lenses	means larger than a standard lens blank to accommodate prescriptions.	CGP-3-GLOSS-90	B750.0790
Photochromic Lenses	means lenses which change color with the intensity of sunlight.	CGP-3-GLOSS-90	B750.0791
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
Plan	means the Davis Vision plan of vision care services described herein.	CGP-3-GLOSS-90	B750.0792

Plano Lenses	means lenses which have no refractive power (lenses with less than a +/- .38 diopter power).	CGP-3-GLOSS-90	B750.0793
Preferred Provider	with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of <i>covered persons</i> of the <i>plan</i> .	CGP-3-GLOSS-90	B750.0794
Standard Lenses	means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.	CGP-3-GLOSS-90	B750.0795
Tinted Lenses	means lenses which have an additional substance added to produce constant tint.	CGP-3-GLOSS-90	B750.0796
Usual	means when referring to a covered charge that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.	CGP-3-GLOSS-90	B750.0797

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

The Guardian's Responsibilities

B800.0048

The vision care 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.

B800.0055

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

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.

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 or convert your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B800.0007

SECTION II: Managed DentalGuard Expense Plan

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

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

B850.0182

GENERAL PROVISIONS

Definitions

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

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

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

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

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

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

Limitation of Authority

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

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

Incontestability

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

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

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

Examination

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

CGP-3-MDG-GP

B850.0561

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures *You and your dependents may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your employer; and (b) returning the enrollment material to your employer. Your employer will forward these materials to Guardian.*

The enrollment materials require *you* to select a *primary care dentist* (PCD) for each *member*. After your enrollment material has been received by Guardian, *we* will determine if a *member's* selected PCD is available in your *plan*. If so, the selected *dentist* will be assigned to the *member* as his or her PCD. If a *member's* selection is not available, an alternate *dentist* will be assigned as the PCD. A *member* need only contact his or her assigned PCD's office to obtain services.

Guardian will issue *you* and your *dependents*, either directly or through your *employer's* representative, a Managed DentalGuard (MDG) identification (ID) card. The ID card will show the *member's* name and the name and telephone number of his or her assigned PCD.

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

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

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

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

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

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

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

Member Eligibility and Termination Provisions (Cont.)

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

We will have:

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

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

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

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

Member Eligibility and Termination Provisions (Cont.)

Benefits for orthodontic services end at the termination of the *member's* coverage under this *plan*.

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

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

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YOUR CONTINUATION RIGHTS

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

An Important Notice About Continuation Rights

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

Federal Continuation Rights

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

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

Under federal law, "marriage" means a legal union between one man and one woman as husband and wife, and "spouse" refers to a person of the opposite sex who is a husband or wife. This plan will allow an active, covered employee's spouse of the same sex and that spouse's dependent children to continue group health benefits under this provision only when: (a) the employer consents; and (b) that employee elects such continuation coverage.

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

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

Federal Continuation Rights (Cont.)

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

Federal Continuation Rights (Cont.)

Such notice must be given to your *employer* within 60 days of either of these events.

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

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

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

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

- (a) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group dental benefits would otherwise end;
- (b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that the continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (c) with respect to continuation upon the your death, your legal divorce or legal separation, or the end of a *dependent's* eligibility, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
- (d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
- (e) the date the *plan* ends;
- (f) the end of the period for which the last premium payment is made;
- (g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or
- (h) the date he or she becomes entitled to Medicare.

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DENTAL EXPENSE COVERAGE

This *plan* will cover many of the dental expenses incurred by *you* and those of your *dependents* who are covered for dental benefits under this *plan*. We decide: (a) the requirements for services to be covered; and (b) what benefits are to be covered by this *plan*. We also interpret how this *plan* is to be administered. What we cover and the terms of coverage are explained below. However, *our* decisions: (a) will not be inconsistent with New York state law; and (b) may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

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

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

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

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

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

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

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

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

We compensate our participating general dentists through an advance payment agreement by which they are paid a fixed amount each month. The amount a participating general dentist is paid is based upon the number of members who have the dentist assigned as their PCD. In addition, we may make minimum monthly payments, supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the participating general dentist receives from us.

The dentist also receives compensation from plan members who may pay an office visit charge for each office visit and a patient charge for specific dental services. The schedule of patient charges is shown in the Covered Dental Services And Patient Charges section of this booklet.

Continuity of Care For New Members

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

- i.) to be reimbursed at contracted rates and payment of any patient charge which may apply, as payment in full;
- ii.) to adhere to our quality assurance requirements;
- iii.) to provide necessary medical information related to such care; and
- iv.) to otherwise adhere to our policies and procedures. The above policies and procedures include, but are not limited to: (a) pre-authorization of referrals; and (b) offering the member a treatment plan approved by us.

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

Changes in Dentist Participation

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

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

Refusal of Recommended Treatment A member may decide to refuse a course of treatment recommended by his or her PCD or participating specialist. The member can request and receive a second opinion by contacting Member Services. If the member still refuses the recommended course of treatment, the PCD or participating specialist may have no further responsibility to provide services for the condition involved and the member may be required to select another PCD or participating specialist.

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

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

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

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

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

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

- (5) A specialty referral is not a guarantee of *covered services*. The *plan's* benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a *covered service* in the *plan*, the *member* will be responsible for the entire amount of the *specialist's* charge for that service.
- (6) A *member* who receives authorized specialty services must pay all applicable *patient charges* associated with the services provided.

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

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

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

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

Out-of-Network Specialty Referrals

A *member's PCD* is responsible for providing all covered services. But, certain services may be eligible for a specialty referral to a *non-participating dentist* if Guardian determines that no *participating dentist* has the appropriate training and experience to provide the dental treatment, procedure or service required to meet the particular dental care needs of a *member*. In such case, Guardian will refer the member to an appropriate *non-participating dentist* pursuant to a treatment plan approved by Guardian in consultation with the *member's PCD*, the *non-participating dentist* and the *member*.

The dental treatment, procedure or service provided by the *non-participating dentist* must otherwise be a *covered service* under the *plan*. A *member* who receives authorized services from a *non-participating dentist* must pay all applicable *patient charges* associated with the services provided.

ANY MEMBER WHO RECEIVES OUT-OF-NETWORK SERVICES WITHOUT PRIOR REFERRAL AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

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

Emergency Dental Services We provide for *emergency dental services* 24 hours a day, 7 days a week, to all *members*. A *member* should contact his or her selected and assigned *PCD*, who will make arrangements for such care. If a *member* is unable to reach his or her *PCD* in an emergency during normal business hours, he or she must call *our* Member Services Department for instructions. If a *member* is unable to reach his or her *PCD* in an emergency after normal business hours, the *member* may seek *emergency dental services* from any *dentist*. Then, within 2 business days, the *member* should call Guardian to advise of the emergency claim. The *member* must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her *PCD*. This must be done within 90 days, or as soon as is reasonably possible. We will reimburse the *member* for 50% of the cost of the *emergency dental services*.

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

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Grievance Process

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

A grievance is used to seek a reversal of a denial of access to a specialty referral (unless the access is denied for reasons of medical necessity); or a determination that a requested benefit is not covered under the *plan*. A grievance is not be used to seek a reversal of an adverse Utilization Review determination. (See the Utilization Review and Utilization Review Appeal Process section in this *plan*.)

When a *general dentist* requests approval for a specialty referral, the request for referral to a *specialist* may be denied if the procedure is routinely performed by a *general dentist*. The *general dentist* will usually agree to perform the procedure; however, if the *general dentist* does not agree, the *plan* may arrange for the *member* to have the procedure done by another *general dentist*. If the *member* seeks to reverse the decision to have the procedure done by another *general dentist*, the Grievance Process, below, is to be followed.

Grievance Process (Cont.)

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

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

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

Grievance Process (Cont.)

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

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

- a) Determinations of denial of access to a referral will be made by a clinical peer reviewer.
- b) Determinations that a benefit is not covered under this *plan* may be made by clinical peer reviewer.

Timeframes Grievances will be resolved as follows:

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

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

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

Notification Written notice of the grievance resolution is forwarded to the *member* or the *member's* Designee and *dentist* in accordance with the above timeframes. The notice will include:

- a) the detailed reasons for the determination; and
- b) the clinical rationale for the determination, when applicable; and
- c) instructions for filing an appeal of the grievance resolution, along with a grievance appeal form.

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

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

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

Grievance Process (Cont.)

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

Timeframes Grievance appeals will be resolved as follows:

Expedited Grievance Appeals: Within 2 business days of receipt of all necessary information where a delay would jeopardize the *member's* health.

Standard Grievance Appeals: Within 30 days after receipt of all necessary information.

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

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

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

Files Each grievance and grievance appeal will be kept on file in *our* Woodland Hills, California office. Grievance files will be labeled with the *member's* name and social security number, and will contain:

- a. the date the grievance was filed;
- b. a copy of the grievance;
- c. the date of *our* receipt of, and a copy of, the *member's* written acknowledgement (i.e. grievance form) of the oral Grievance which began the grievance process;
- d. a copy of the grievance determination and the date of the determination;
- e. the title and, for a clinical determination, the credentials of the clinical peer reviewer who reviewed the grievance, if applicable;
- f. a copy of the grievance appeal, if applicable;
- g. a copy of the grievance appeal determination, if applicable, and the date of the determination; and
- h. the name, title and credentials of the clinical peer reviewer who reviewed the grievance appeal, if applicable.

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

CGP-3-MDG-NY-GRV-08

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Utilization Review and Utilization Review Appeal Process

Definitions "Adverse Determination (AD)" means a determination by a General or Specialist Dentist reviewer, as appropriate, that a dental service is not medically necessary.

"Disabling Condition or Disease" means any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than 12 months, which renders the Member unable to engage in any substantial gainful activities. In the case of a child under the age of 18, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

"External Appeal" means an appeal conducted by an External Appeal Agent.

"External Appeal Agent" means an entity certified by the State of New York to conduct external appeals.

"Life-threatening Condition or Disease" means one which, according to the current diagnosis of a Member's PCD, has a high probability of death.

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

"Out-of-Network Denial (OND)" means a denial of a request for pre-authorization to receive a particular dental service from a Non-Participating Dentist on the basis that such service is not materially different than the dental service available from a Participating Dentist. An Out-of-Network Denial is not an Adverse Determination.

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

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

Utilization Review Process **Overview:** A review in the Utilization Review Process is conducted by a General or Specialist Dentist reviewer, as appropriate, who will make a determination as to whether a dental service is medically necessary.

Policies and Procedures: We perform UR on specialty referral services. When preparing a Member's treatment plan, a PCD may identify the need for more complex treatment which requires the skills of a Specialist. All referrals to a Specialist must be consistent with a treatment plan that has been communicated to the Member. The PCD must submit a Specialty Referral Form to Us for: (a) pre-authorization of all non-emergency treatment; and (b) approval of referral of a Member to a Specialist. This process allows Us to monitor the frequency and appropriateness of the requested treatment. We have established Specialty Referral Guidelines for Participating Dentists. These guidelines include procedures for authorization and payment of specialty referrals. Specialty referrals which have been denied for reasons of medical necessity will follow the process described below.

Utilization Review and Utilization Review Appeal Process (Cont.)

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

Time Frames for UR determinations **A) Prospective Determinations**

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

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

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

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

Notification of UR Determinations We will inform the Member and the Dentist by telephone and in writing of an AD. The written notice will

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

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

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

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

Utilization Review and Utilization Review Appeal Process (Cont.)

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

If a Member or Dentist has utilized the Reconsideration Process and is still dissatisfied with the outcome, the Dentist or Member may: (a) request that an initial AD or Reconsideration be further re-evaluated (i.e., a URA); and (b) submit additional information for the re-evaluation. A URA may be submitted by: (a) a Member; (b) a person acting on behalf of a Member; or (c) only in the case of a retrospective AD, a Member's Dentist.

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Out-of-Network Denial An Out-of-Network Denial (OND) is the denial of a Member's request for pre-authorization to receive a particular dental service from a Non-Participating Dentist on the basis that such service is not materially different than the dental service available from a Participating Dentist. The notice of an OND will indicate what necessary information must be provided in order to appeal the OND. An OND is not an Adverse Determination.

If a Member or Dentist is dissatisfied with the OND, the Dentist or Member may: (a) request that the OND be re-evaluated (i.e., a URA); and (b) submit the following information for the re-evaluation:

- a.) a written statement from the Member's Dentist that the requested out-of-network dental service is materially different from the service the Plan approved to treat the Member's dental care needs; and
- b.) 2 documents from the available dental and scientific evidence that the out-of-network dental service is likely to be more beneficial to the Member than any covered, standard dental procedure.

Utilization Review Appeals Process The Standard and Expedited URA Review will be reviewed by a General or Specialist Dentist reviewer, as appropriate, other than the original Dentist reviewer. This is done under the supervision of the Dental Director or a person named by him or her.

Standard URA Process: URAs may be received by telephone or in writing. The Member or his or her Dentist may contact the QCL at 1-888-618-2016 between 9:30 a.m. and 7:30 p.m., Eastern Time, or by mail to P.O. Box 4391, Woodland Hills, CA 91367 to request a URA.

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

Utilization Review and Utilization Review Appeal Process (Cont.)

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

CGP-3-MDG-NY-UR-08

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Utilization Review and Utilization Review Appeal Process (Cont.)

External Appeal Process **Overview:** A Member and/or his or her Dentist have the right to External Appeal of a final AD or OND after exhausting our internal review processes. The Member or Dentist may request an External Appeal of a final AD or OND under any of the following circumstances

- (1) A procedure that would otherwise be a covered service under the Plan is denied on appeal, in whole or in part, on the grounds that such procedure is not medically necessary; and (a) Guardian has rendered a final AD with respect to such procedure; or (b) both the Member and Guardian have jointly agreed to waive any internal appeal.
- (2) A procedure that would otherwise be a covered service under the Plan is denied on the basis that such procedure is experimental or investigational, and (a) Guardian has rendered a final AD with respect to such procedure; or (b) both the Member and Guardian have jointly agreed to waive any internal appeal; and a Member's Dentist has certified that the Member has a Life-Threatening Condition or Disease or a Disabling Condition or Disease:
 - a.) for which standard dental services or procedures have been ineffective or would be medically inappropriate; or
 - b.) for which there does not exist a more beneficial standard dental service or procedure covered by the Plan; or
 - c.) for which there exists a clinical trial.

The Member's Dentist must have recommended either:

- (i) a dental treatment, based on 2 documents from the available dental and scientific evidence, which is likely to be more beneficial to the Member than any covered, standard dental procedure; or
 - (ii) a clinical trial for which The Member is eligible.
- (3) A procedure that would otherwise be a covered service under the Plan is denied on appeal, in whole or in part, on the grounds that such procedure is out-of-network and an alternate recommended treatment is available in-network; and (a) Guardian has rendered a final OND with respect to such procedure; or (b) both the Member and Guardian have jointly agreed to waive any internal appeal.

The Member's Dentist must have:

- (i) certified that the requested out-of-network dental service is materially different from the service the Plan approved to treat the Member's dental care needs; or
- (ii) recommended a dental procedure, based on 2 documents from the available dental and scientific evidence, which is likely to be more beneficial to the Member than any covered, standard dental procedure.

Utilization Review and Utilization Review Appeal Process (Cont.)

Any Dentist certification provided under this section will include a statement of the evidence relied upon by the Dentist in certifying his or her recommendation. And the specific dental procedure recommended by the Dentist would otherwise be covered under the Plan had Guardian not determined that the dental procedure is: (a) experimental or investigational; or (b) out-of-network and an alternate recommended treatment is available in-network.

Standard External Appeal: An External Appeal must be initiated in writing within 45 days after:

- (1) the date the Member receives notification of the final AD or OND; or
- (2) the date the Member receives notification of waiver of the internal appeal process, if the Member and Guardian have jointly agreed to waive any internal appeal.

In either case, the notification letter will include instructions and forms for initiating an External Appeal.

The Member may also initiate an External Appeal by requesting an External Appeal request form from the New York State Insurance Department by calling 1-800-400-8882; and mailing the completed form to the Insurance Department at the address shown on the form. If the Member satisfies the criteria for an External Appeal, the State will send the request for appeal to a certified External Appeal Agent.

The Member will have an opportunity to submit additional documentation with the request for External Appeal. If the External Appeal Agent determines that the information submitted represents a material change from the information on which Guardian based its denial, the External Appeal Agent will share this information with Guardian so that We may exercise Our right to reconsider Our decision. If Guardian chooses to exercise this right, We will have 3 business days to amend or confirm Our decision. In the case of an Expedited External Appeal, We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Member's completed request for External Appeal. The External Appeal Agent may request additional information from the Member, the Member's dentist, or Guardian. If the External Appeal Agent requests additional information, it will have 5 additional business days to make its decision. The External Appeal Agent must notify the Member in writing of its decision within 2 business days.

Expedited External Appeal: If the Member's dentist certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Member's health, the Member may request an expedited External Appeal. In that case, the External Appeal Agent must make a decision within 3 days of receipt of the completed request for External Appeal. Immediately after reaching a decision, the External Appeal Agent must try to notify the Member and Guardian by telephone or facsimile of that decision. The External Appeal Agent must also notify the Member in writing of its decision.

Utilization Review and Utilization Review Appeal Process (Cont.)

If the External Appeal Agent overturns Guardian's final AD or OND, Guardian will provide coverage subject to the other terms and conditions of this Plan. If the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, Guardian will only cover the costs of services required to provide treatment to the Member according to the design of the trial. Guardian will not pay for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under this Plan for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Member and Guardian. The External Appeal Agent's decision is admissible in any court proceeding.

Guardian may charge the Member a fee of up to \$50 per External Appeal. This fee is refundable to the Member in the event that the External Appeal Agent overturns Guardian's final AD or OND. Guardian will not require the Member to pay any such fee if such fee will pose a hardship to him or her, as determined by Guardian.

After the Plan's internal and external review and appeal processes have been exhausted, the Member and Guardian each have the right to use the legal system for any claim involving the professional treatment performed by a Participating Dentist.

CGP-3-MDG-NY-UR-08

B850.0968

Covered Dental Services And Patient Charges - Plan U10 M

The services covered by this Plan are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the assigned PCD.

The Member must pay the listed Patient Charge. The benefits We provide are subject to all the terms of this Plan, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

The Patient Charges listed in this section are only valid for covered services that are: (1) started and completed under this Plan, and (2) rendered by Participating Dentists in the state of New York.

CDT Code	Covered Services and Patient Charges - U10 M Current Dental Terminology (CDT) © American Dental Association (ADA)	Patient Charge
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D0999	Office visit during regular hours, general dentist only	\$5.00
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EVALUATIONS

D0120	Periodic oral evaluation - established patient	\$0.00
D0140	Limited oral evaluation - problem focused	\$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	\$0.00
D0150	Comprehensive oral evaluation - new or established patient	\$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	\$0.00

RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)

D0210	Intraoral - complete series (including bitewings)	\$0.00
D0220	Intraoral - periapical - first film	\$0.00
D0230	Intraoral - periapical - each additional film	\$0.00
D0240	Intraoral - occlusal film	\$0.00
D0270	Bitewing - single film	\$0.00
D0272	Bitewings - 2 films	\$0.00
D0273	Bitewings - 3 films	\$0.00
D0274	Bitewings - 4 films	\$0.00
D0277	Vertical bitewings - 7 to 8 films	\$0.00
D0330	Panoramic film	\$0.00

TESTS AND EXAMINATIONS

D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$50.00
D0460	Pulp vitality tests	\$0.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

D0470 Diagnostic casts \$0.00

DENTAL PROPHYLAXIS

D1110 Prophylaxis - adult, for the first two services in any
12-month period ^{1, 2} \$0.00

D1120 Prophylaxis - child, for the first two services in any
12-month period ^{1, 2} \$0.00

D1999 Prophylaxis - adult or child, for each additional service in same
12-month period ^{1, 2} \$60.00

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

D1203 Topical application of fluoride (prophylaxis not included) - child,
for the first two services in any 12-month period ^{1, 3} \$0.00

D1204 Topical application of fluoride (prophylaxis not included) - adult,
for the first two services in any 12-month period ^{1, 3} \$0.00

D1206 Topical fluoride (prophylaxis not included) - child,
for the first two services in any 12-month period ^{1, 3} \$12.00

D2999 Topical fluoride, adult or child, for each additional service in
same 12-month period ^{1, 3} \$20.00

OTHER PREVENTIVE SERVICES

D1310 Nutritional instruction for control of dental disease \$0.00

D1330 Oral hygiene instructions \$0.00

D1351 Sealant - per tooth (molars) ⁴ \$14.00

D9999 Sealant - per tooth (non-molars) ⁴ \$35.00

SPACE MAINTENANCE (PASSIVE APPLIANCES)

D1510 Space maintainer - fixed - unilateral \$75.00

D1515 Space maintainer - fixed - bilateral \$110.00

D1525 Space maintainer - removable - bilateral \$110.00

D1550 Re-cementation of fixed space maintainer \$13.00

D1555 Removal of fixed space maintainer \$20.00

ALMAGAM RESTORATIONS (INCLUDING POLISHING)

D2140 Amalgam - 1 surface, primary or permanent \$28.00

D2150 Amalgam - 2 surfaces, primary or permanent \$39.00

D2160 Amalgam - 3 surfaces, primary or permanent \$46.00

D2161 Amalgam - 4 or more surfaces, primary or permanent \$57.00

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT

D2330 Resin-based composite - 1 surface, anterior \$36.00

D2331 Resin-based composite - 2 surfaces, anterior \$44.00

D2332 Resin-based composite - 3 surfaces, anterior \$58.00

D2335 Resin-based composite - 4 or more surfaces or involving incisal
angle, (anterior) \$66.00

D2390 Resin-based composite crown, anterior \$95.00

D2391 Resin-based composite - 1 surface, posterior \$56.00

D2392 Resin-based composite - 2 surfaces, posterior \$75.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

D2393	Resin-based composite - 3 or more surfaces, posterior	\$90.00
D2394	Resin-based composite - 4 or more surfaces, posterior	\$95.00

INLAY/ONLAY RESTORATIONS ⁶

D2510	Inlay - metallic - 1 surface ⁵	\$326.00
D2520	Inlay - metallic - 2 surfaces ⁵	\$368.00
D2530	Inlay - metallic - 3 or more surfaces ⁵	\$383.00
D2542	Onlay - metallic - 2 surfaces ⁵	\$383.00
D2543	Onlay - metallic - 3 surfaces ⁵	\$400.00
D2544	Onlay - metallic - 4 or more surfaces ⁵	\$420.00
D2610	Inlay - porcelain/ceramic - 1 surface	\$326.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	\$368.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	\$383.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	\$383.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	\$400.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	\$420.00

CROWNS - SINGLE RESTORATIONS ONLY ⁶

D2740	Crown - porcelain/ceramic substrate	\$450.00
D2750	Crown - porcelain fused to high noble metal ⁵	\$430.00
D2751	Crown - porcelain fused to predominantly base metal	\$430.00
D2752	Crown - porcelain fused to noble metal	\$430.00
D2780	Crown - 3/4 cast high noble metal ⁵	\$420.00
D2781	Crown - 3/4 cast predominantly base metal	\$420.00
D2782	Crown - 3/4 cast noble metal	\$420.00
D2783	Crown - 3/4 porcelain/ceramic	\$420.00
D2790	Crown - full cast high noble metal ⁵	\$430.00
D2791	Crown - full cast predominantly base metal	\$430.00
D2792	Crown - full cast noble metal	\$430.00
D2794	Crown - titanium	\$430.00

OTHER RESTORATIVE SERVICES

D2910	Recement inlay, onlay, or partial coverage restoration	\$18.00
D2915	Recement cast or prefabricated post and core	\$18.00
D2920	Recement crown	\$18.00
D2930	Prefabricated stainless steel crown - primary tooth	\$110.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$125.00
D2932	Prefabricated resin crown	\$135.00
D2933	Prefabricated stainless steel crown with resin window	\$135.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	\$145.00
D2940	Sedative filling	\$30.00
D2950	Core buildup, including any pins	\$113.00
D2951	Pin retention - per tooth, in addition to restoration	\$24.00
D2952	Post & core in addition to crown, indirectly fabricated	\$160.00
D2953	Each additional indirectly fabricated post - same tooth	\$50.00
D2954	Prefabricated post and core in addition to crown	\$130.00
D2957	Each additional prefabricated post - same tooth	\$29.00
D2960	Labial veneer (resin laminate) - chairside	\$250.00
D2970	Temporary crown (fractured tooth)	\$100.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

D2971 Additional procedures to construct new crown under existing partial denture framework \$125.00

PULP CAPPING

D3110 Pulp cap - direct (excluding restoration) \$15.00

D3120 Pulp cap - indirect (excluding restoration) \$15.00

PULPOTOMY

D3220 Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament \$50.00

D3221 Pulpal debridement, primary and permanent teeth \$50.00

D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development \$50.00

D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) \$88.00

D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration) \$90.00

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

D3310 Root canal, anterior (excluding final restoration) \$260.00

D3320 Root canal, bicuspid (excluding final restoration) \$300.00

D3330 Root canal, molar (excluding final restoration) \$400.00

D3331 Treatment of root canal obstruction; non-surgical access \$0.00

D3332 Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth \$150.00

D3333 Internal root repair or perforation defects \$120.00

ENDODONTIC RETREATMENT

D3346 Retreatment of previous root canal therapy - anterior \$315.00

D3347 Retreatment of previous root canal therapy - bicuspid \$370.00

D3348 Retreatment of previous root canal therapy - molar \$445.00

APICOECTOMY/PERIRADICULAR SERVICES

D3410 Apicoectomy/periradicular surgery - anterior \$265.00

D3421 Apicoectomy/periradicular surgery - bicuspid (first root) \$300.00

D3425 Apicoectomy/periradicular surgery - molar (first root) \$350.00

D3426 Apicoectomy/periradicular surgery (each additional root) \$110.00

D3430 Retrograde filling - per root \$90.00

D3950 Canal preparation and fitting of preformed dowel or post \$20.00

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)

D4210 Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant \$188.00

D4211 Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant \$85.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$275.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$165.00
D4249	Clinical crown lengthening - hard tissue	\$285.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$410.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$350.00
D4268	Surgical revision procedure, per tooth	\$0.00
D4270	Pedicle soft tissue graft procedure	\$295.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$298.00
D4273	Subepithelial connective tissue graft procedures, per tooth	\$328.00

NON-SURGICAL PERIODONTAL SERVICE

D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	\$50.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	\$30.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$35.00

OTHER PERIODONTAL SERVICES

D4910	Periodontal maintenance, for the first two services in any 12-month period ^{1, 2}	\$32.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$25.00
D4999	Periodontal maintenance, for each additional service in same 12-month period ^{1, 2}	\$60.00

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5110	Complete denture - maxillary	\$580.00
D5120	Complete denture - mandibular	\$580.00
D5130	Immediate denture - maxillary	\$620.00
D5140	Immediate denture - mandibular	\$620.00

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$580.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$580.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$620.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$620.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$675.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$675.00

ADJUSTMENTS TO DENTURES

D5410	Adjust complete denture - maxillary	\$27.00
D5411	Adjust complete denture - mandibular	\$27.00
D5421	Adjust partial denture - maxillary	\$27.00
D5422	Adjust partial denture - mandibular	\$27.00

REPAIRS TO COMPLETE DENTURES

D5510	Repair broken complete denture base	\$69.00
D5520	Replace missing or broken teeth - complete denture (each tooth) . . .	\$66.00

REPAIRS TO PARTIAL DENTURES

D5610	Repair resin denture base	\$80.00
D5620	Repair cast framework	\$80.00
D5630	Repair or replace broken clasp	\$96.00
D5640	Replace broken teeth - per tooth	\$62.00
D5650	Add tooth to existing partial denture	\$81.00
D5660	Add clasp to existing partial denture	\$102.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	\$223.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	\$223.00

DENTURE REBASE PROCEDURES

D5710	Rebase complete maxillary denture	\$230.00
D5711	Rebase complete mandibular denture	\$230.00
D5720	Rebase maxillary partial denture	\$230.00
D5721	Rebase mandibular partial denture	\$230.00

DENTURE RELINE PROCEDURES

D5730	Reline complete maxillary denture (chairside)	\$130.00
D5731	Reline complete mandibular denture (chairside)	\$130.00
D5740	Reline maxillary partial denture (chairside)	\$125.00
D5741	Reline mandibular partial denture (chairside)	\$125.00
D5750	Reline complete maxillary denture (laboratory)	\$186.00
D5751	Reline complete mandibular denture (laboratory)	\$186.00
D5760	Reline maxillary partial denture (laboratory)	\$186.00
D5761	Reline mandibular partial denture (laboratory)	\$186.00

INTERIM PROSTHESIS

D5820	Interim partial denture (maxillary)	\$190.00
D5821	Interim partial denture (mandibular)	\$190.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

OTHER REMOVABLE PROSTHETIC SERVICES

D5850	Tissue conditioning, maxillary	\$60.00
D5851	Tissue conditioning, mandibular	\$60.00

FIXED PARTIAL DENTURE PONTICS ⁶

D6210	Pontic - cast high noble metal ⁵	\$400.00
D6211	Pontic - cast predominantly base metal	\$400.00
D6212	Pontic - cast noble metal	\$400.00
D6214	Pontic - titanium	\$400.00
D6240	Pontic - porcelain fused to high noble metal ⁵	\$400.00
D6241	Pontic - porcelain fused to predominantly base metal	\$400.00
D6242	Pontic - porcelain fused to noble metal	\$400.00
D6245	Pontic - porcelain/ceramic	\$410.00

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS ⁶

D6600	Inlay - porcelain/ceramic, - 2 surface	\$368.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	\$383.00
D6602	Inlay - cast high noble metal, - 2 surfaces ⁵	\$368.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces ⁵	\$383.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	\$368.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	\$383.00
D6606	Inlay - cast noble metal, 2 surfaces	\$368.00
D6607	Inlay - cast noble metal, 3 or more surfaces	\$383.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	\$383.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	\$400.00
D6610	Onlay - cast high noble metal, 2 surfaces ⁵	\$383.00
D6611	Onlay - cast high noble metal, 3 or more surfaces ⁵	\$400.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	\$383.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	\$400.00
D6614	Onlay - cast noble metal, 2 surfaces	\$383.00
D6615	Onlay - cast noble metal, 3 or more surfaces	\$400.00
D6624	Inlay - titanium	\$368.00
D6634	Onlay - titanium	\$383.00

FIXED PARTIAL DENTURE RETAINERS - CROWNS ⁶

D6740	Crown - porcelain/ceramic	\$450.00
D6750	Crown - porcelain fused to high noble metal ⁵	\$430.00
D6751	Crown - porcelain fused to predominantly base metal	\$430.00
D6752	Crown - porcelain fused to noble metal	\$430.00
D6780	Crown - 3/4 cast high noble metal ⁵	\$430.00
D6781	Crown - 3/4 cast predominantly base metal	\$430.00
D6782	Crown - 3/4 cast noble metal	\$430.00
D6783	Crown - 3/4 porcelain/ceramic	\$430.00
D6790	Crown - full cast high noble metal ⁵	\$430.00
D6791	Crown - full cast predominantly base metal	\$430.00
D6792	Crown - full cast noble metal	\$430.00
D6794	Crown - titanium	\$430.00

OTHER FIXED PARTIAL DENTURE SERVICES

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

D6930	Recement fixed partial denture	\$26.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$160.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$130.00
D6973	Core buildup for retainer, including any pins	\$113.00
D6976	Each additional cast post - same tooth	\$50.00
D6977	Each additional prefabricated post - same tooth	\$29.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment ⁶	\$125.00

EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth	\$20.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$35.00

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$110.00
D7220	Removal of impacted tooth - soft tissue	\$145.00
D7230	Removal of impacted tooth - partially bony	\$180.00
D7240	Removal of impacted tooth - completely bony	\$215.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$240.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$110.00
D7261	Primary closure of a sinus perforation	\$250.00

OTHER SURGICAL PROCEDURES

D7280	Surgical access of an unerupted tooth	\$250.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$35.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$125.00
D7286	Biopsy of oral tissue - soft	\$85.00
D7288	Brush biopsy - transepithelial sample collection	\$65.00

ALEVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$53.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	\$26.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	\$92.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	\$65.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$200.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$260.00

EXCISION OF BONE TISSUE

D7471	Removal of lateral exostosis (maxilla or mandible)	\$215.00
D7472	Removal of torus palatinus	\$215.00
D7473	Removal of torus mandibularis	\$215.00

SURGICAL INCISION

D7510	Incision and drainage of abscess - intraoral soft tissue	\$44.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$48.00

OTHER REPAIR PROCEDURES

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$100.00
D7963	Frenuloplasty	\$168.00

UNCLASSIFIED TREATMENT

D9110	Palliative (emergency) treatment of dental pain - minor procedure . . .	\$25.00
D9120	Fixed partial denture sectioning	\$30.00
D9215	Local anesthesia	\$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes ⁷	\$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes ⁷	\$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes ⁷	\$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes ⁷	\$75.00

PROFESSIONAL CONSULTATION

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	\$34.00
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PROFESSIONAL VISITS

D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$10.00
D9440	Office visit - after regularly scheduled hours	\$50.00
D9450	Case presentation, detailed and extensive treatment planning	\$0.00

MISCELLANEOUS SERVICES

D9951	Occlusal adjustment - limited	\$23.00
D9971	Odontoplasty, 1-2 teeth	\$23.00
D9972	External bleaching - per arch	\$165.00
	Broken Appointment	\$25.00

Covered Dental Services And Patient Charges Plan U10 M (Cont.)

- ¹ The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first 2 services in any 12-month period. For each additional services in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.
- ² Routine prophylaxis or periodontal maintenance procedure - a total of 4 services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a *participating periodontal specialty care dentist* if done within 3 to 6 months following completion of approved, active periodontal therapy (periodontal scaling and root planning or periodontal osseous surgery) by a *participating periodontal specialty care dentist*. Active periodontal therapy includes periodontal scaling and root planning or periodontal osseous surgery.
- ³ Fluoride treatment - a total of 4 services in any 12-month period.
- ⁴ Sealants are limited to permanent teeth up to the 16th birthday.
- ⁵ If high noble metal is used, there will be an additional Patient Charge for the actual cost of the high noble metal.
- ⁶ The *patient charge* for these services is per unit.
- ⁷ Procedure codes D9220, D9221, D9241 and D9242 are limited to a *participating specialty care oral surgeon*. Additionally, these services are only covered in conjunction with other covered surgical services.

Additional Conditions On Covered Services (Cont.)

The *plan* provides for the use of noble, high noble and base metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, the *member* will pay an additional amount for the actual cost of the high noble metal. In addition, the *member* will pay the usual *patient charge* for the inlay, onlay, crown or fixed bridge. The total *patient charges* for high noble metal may not exceed the actual lab bill for the service.

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

General Guidelines For Alternative Treatment By The PCD There may be a number of accepted methods for treating a specific dental condition. In all cases where there is more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *member* with a written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the *member* should pay, and to fully document informed consent.

- If any of the recommended alternate services are selected by the *member* and not covered under the *plan*, then the *member* must pay the *PCD's* usual charge for the recommended alternate service.
- If any treatment is specifically not recommended by the *PCD* (i.e., the *PCD* determines it is not an appropriate service for the condition being treated), then the *PCD* is not obliged to provide that treatment even if it is a covered service under the *plan*.
- *Members* can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the *PCD* or *participating specialist*.

Crowns, Bridges And Dentures A crown is a covered service when it is recommended by the *PCD*. The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan*. The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by relining, rebase or repair. Construction of new dentures may not exceed one each in any 5-year period from the date of previous placement under the *plan*. Immediate dentures are not subject to the 5-year limitation.

The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6 months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture. Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the *PCD*.

Additional Conditions On Covered Services (Cont.)

Multiple Crown/Bridge Unit Treatment Fee When a *member's* treatment plan includes 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the *member* will be responsible for the *patient charge* for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

CGP-3-MDG-NY-COND-08

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Pediatric Specialty Services If, during a *PCD* visit, a *member* under age 8 is unmanageable, the *PCD* may refer the *member* to a *participating pediatric specialist* for the current treatment plan only. Following completion of the approved pediatric treatment plan, the *member* must return to the *PCD* for further services. If necessary, we must first authorize subsequent referrals to the *participating specialist*. Any services performed by a *participating pediatric specialist* after the *member's* 8th birthday will not be covered, and the *member* will be responsible for the *participating pediatric specialist's* usual fees.

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

A Member Services Representative will help the *member* identify a *participating dentist* to perform the second opinion consultation. The *member* may request a second opinion with a *non-participating general dentist or specialist*. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting *dentist*. The second opinion consultation shall have the applicable *patient charge* for code D9310.

Third opinions are not covered unless requested by us. If a third opinion is requested by the *member*, the *member* is responsible for the payment. Exceptions will be considered on an individual basis, and must be approved in writing by us.

The *plan's* benefit for a second opinion consultation is limited to \$50.00. If a *participating dentist* is the consultant *dentist*, the *member* is responsible for the applicable *patient charge* for code D9310. If a non-participating dentist is the consultant dentist, the member must pay the applicable patient charge for code D9310 and any portion of the dentist's fee over \$50.00.

Noble and High Noble Metals The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the member will be responsible for the patient charge for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

Additional Conditions On Covered Services (Cont.)

General Anesthesia / IV Sedation General anesthesia / IV sedation - General anesthesia or IV sedation is limited to services provided by a participating oral surgery specialist. Not all participating oral surgery specialists offer these services. The member is responsible to identify and receive services from a participating oral surgery specialist willing to provide general anesthesia or IV sedation. The member's patient charge is shown in the Covered Dental Services and Patient Charges section.

Office Visit Charges Office visit patient charges that are the member's responsibility after the employer's group plan has been in effect for 3 full years, will be paid to the PCD by us.

CGP-3-MDG-NY-COND-08

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Orthodontic Treatment The *plan* covers orthodontic services as shown in the Covered Dental Services and Patient Charges section. Coverage is limited to one course of treatment per *member*. We must preauthorize treatment, and treatment must be performed by a *participating orthodontic specialist*.

The *plan* covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, the *member* must pay an added charge for each added month of treatment. Such charge is based on the *participating orthodontist's* contracted fee.

Except as described under Treatment in Progress-Orthodontic Treatment and Treatment in Progress - Takeover Benefit for Orthodontic Treatment, orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the *plan*. If a *member's* coverage terminates after the fixed banding appliances are inserted, the *participating orthodontic specialist* may prorate his or her usual fee over the remaining months of treatment. The *member* is responsible for all payments to the *participating orthodontic specialist* for services after the termination date. Retention services are covered at the *patient charge* shown in the *plan* Schedule's section only following a course of comprehensive orthodontic treatment started and completed under this *plan*.

If a *member* transfers to another *orthodontic specialist* after authorized comprehensive orthodontic treatment has started under this *plan*, the *member* must pay any additional costs associated with the change in *orthodontic specialist* and subsequent treatment.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. The *member* must pay for any additional fixed or removable appliances. The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. The *member* must pay any additional costs for the use of optional materials.

Additional Conditions On Covered Services (Cont.)

If a *member* has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the *plan* provides the standard orthodontic benefit. The *member* must pay any additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the *participating orthodontic specialist's* usual fee.

CGP-3-MDG-NY-ORTHO-R-08

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Treatment In Progress

A *member* may choose to have a *participating dentist* complete an inlay, onlay, crown, fixed bridge, denture, or root canal, or orthodontic treatment procedure which: (1) is listed in the Covered Dental Services and Patient Charges section; and (2) was started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. The *member* is responsible to identify, and transfer to, a *participating dentist* willing to complete the procedure at the *patient charge* described in this section.

- Restorative Treatment - Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the *member's* eligibility to receive benefits under this *plan*, have a *patient charge* equal to 85% of the *participating general dentist's* usual fee. (There is no additional charge for high noble metal.)
- Endodontic Treatment - Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are shown in the Covered Dental Services and Patient Charges section that were started but not completed prior to the *member's* eligibility to receive benefits under this *plan* may be covered if the *member* identifies a *participating general dentist or specialist* who is willing to complete the procedure at a *patient charge* equal to 85% of *participating dentist's* usual fee.
- Orthodontic Treatment - Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the *member's* eligibility to receive benefits under this *plan* may be covered if the *member* identifies a *participating orthodontic specialist* who is willing to complete the treatment, including retention, at a *patient charge* equal to 85% of the *participating orthodontic specialist's* usual fee. Also refer to the Treatment in Progress - Takeover Benefit for Orthodontic Treatment section.

Treatment in Progress - Takeover Benefit for Orthodontic Treatment

The Treatment in Progress - Takeover Benefit for Orthodontic Treatment provides a *member* who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another dental HMO plan with the current treating orthodontist, after *this plan* becomes effective. A *member* may be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment only if:

Additional Conditions On Covered Services (Cont.)

- the *member* was covered by another dental HMO plan just prior to the effective date of *this plan* and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with a participating network orthodontist under the prior dental HMO plan;
- the *member* has such orthodontic treatment in progress at the time *this plan* becomes effective;
- the *member* continues such orthodontic treatment with the treating orthodontist;
- the *member's* payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental HMO plan; and
- a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form, completed by the treating orthodontist, is submitted to *us* within 6 months of the effective date of *this plan*.

The benefit amount will be calculated based on: (i) the number of remaining months of comprehensive orthodontic treatment; and (ii) the amount by which the *member's* payment responsibility has increased as a result of the treating orthodontist's raised fees, up to a maximum benefit of \$500 per Member.

The *member* will be responsible to have the treating orthodontist complete a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form and submit it to *us*. The *member* has 6 months from the effective date of *this plan* to have the Form submitted to *us* in order to be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment. *We* will determine the *member's* additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The *member* will be paid quarterly until the benefit has been paid or until the *member* completes treatment, whichever comes first. The benefit will cease if the *member's* coverage under *this plan* is terminated.

This benefit is only available to *members* that were covered under the prior dental HMO plan and are in comprehensive orthodontic treatment with a participating network orthodontist when *this plan* becomes effective with *us*. It will not apply if the comprehensive orthodontic treatment was started when the *member* was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the *member* transfers to another orthodontist. This benefit applies to *members* of new *plans* only. It does not apply to *members* of existing *plans*. And it does not apply to persons who become newly eligible under the Group after the effective date of *this plan*.

The benefit is only available to *members* in comprehensive orthodontic treatment (D8070, D8080 or D8090). It does not apply to any other orthodontic services. Additionally, *we* will only cover up to a total 24 months of comprehensive orthodontic treatment. Treatment In Progress

CGP-3-MDG-NY-TIP-R-08

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Limitations on Benefits For Specific Covered Services

NOTE: Time limitations for a service are determined from the date that service was last rendered under this *plan*.

The codes below in parentheses refer to the CDT Codes as shown in the Covered Dental Services and Patient Charges section.

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) - a total of 4 services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a *participating periodontal specialist* if done within 3 to 6 months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a *participating periodontal specialist*. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D2999) - 4 in any 12 month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to 1 in any 2-year period on or after the 40th birthday.
- Full mouth x-rays - 1 set in any 3-year period.
- Bitewing x-rays - 2 sets in any 12-month period.
- Panoramic x-rays - 1 set in any 3-year period.
- Sealants - limited to permanent teeth, up to the 16th birthday - 1 per tooth in any 3-year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) - a total of 1 service per quadrant or area in any 3-year period.
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) - a total of 1 service per area in any 3-year period.
- Periodontal scaling and root planning (D4341, D4342) - 1 service per quadrant or area in any 12-month period.
- Emergency dental services when more than 50 miles from the *PCD's* office - limited to a \$50.00 per incident, after payment of any *patient charge* which may apply.
- Emergency dental services when provided by a dentist other than the Member's assigned *PCD*, and without referral by the *PCD* or authorization by us - limited to 50% of the cost for emergency dental services.
- Reline of a complete or partial denture - 1 per denture in 12-month period.

Limitations on Benefits For Specific Covered Services (Cont.)

- Rebase of a complete or partial denture - 1 per denture in any 12-month period.
- Second Opinion Consultation - when approved by *us*, a second opinion consultation will be reimbursed up to \$50.00 per treatment plan.

CGP-3-MDG-NY-LMTS-R-08

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Exclusions

We won't cover:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any histopathological examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Placement of osseous (bone) grafts.
- Any treatment or appliances requested, recommended or performed which is solely for cosmetic purposes. Excluded services do not include: (i) reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; (ii) reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect; (iii) care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; and (iv) care or treatment necessary due to congenital disease or anomaly.
- Precision attachments, stress breakers, magnetic retention or overdenture attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
- Any procedure or treatment method: (a) which is not a *medically necessary service*; or (b) which is considered to be experimental in nature. This does not apply if coverage is recommended by a utilization review agent. See the "Utilization Review and Utilization Review Appeal Process" in this booklet.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.

Exclusions (Cont.)

- Replacement or repair of prosthetic appliances damaged due to the neglect of the *member*.
- Any *member* request for: (a) *specialist* services or treatment which can be routinely provided by the *PCD*, or (b) treatment by a *specialist* without a referral from the *PCD* and approval from *us*.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless *we* are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ) that are incidental to or result from a medical condition.
- Dental services, other than covered *emergency dental services*, which were performed by any *dentist* other than the *member's* assigned *PCD*, unless *we* had provided written authorization.
- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a prosthodontist.
- Treatment which requires the services of a *pediatric specialist*, after the *member's* 8th birthday.
- Consultations for non-covered services.
- Any procedure not specifically listed as a covered service in the Covered Dental Services and Patient Charges section.

CGP-3-MDG-NY-EXCL-R-08

B850.0977

- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan*, except as described under Treatment in Progress-Restorative Treatment. (Inlays, onlays crowns or fixed bridges are considered to be: (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are considered to be: (a) started when the impressions are taken, and (b) completed when the denture is delivered to the *member*.)

Exclusions (Cont.)

- Root canal treatment started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan*, except as described under Treatment in Progress-Endodontic Treatment. (Root canal treatment is considered to be: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)
- Orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan*, except as described under Treatment in Progress-Orthodontic Treatment and Treatment in Progress-Takeover Benefit for Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)
- Inlays, onlays, crowns, fixed bridges or dentures started by a *non-participating dentist*. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the *plan* as *emergency dental services*.
- Root canal treatment started by a *non-participating dentist*. (Root canal treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the *plan* as *emergency dental services*.
- Orthodontic treatment started by a *non-participating dentist* while the *member* is covered under this *plan*. (Orthodontic treatment is considered to be started when the teeth are banded.)
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

Exclusions (Cont.)

- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the *member*.

CGP-3-MDG-NY-EXCL-R-08

B850.1224

GLOSSARY

This Glossary defines the italicized terms appearing in this booklet.

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

CGP-3-MDG-DEF1

B850.0595

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

CGP-3-MDG-DEF2

B850.0596

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

CGP-3-MDG-DEF3

B850.0597

Dependent means a person listed on the *employee's* enrollment form who is:

- (1) your spouse; or
- (2) your or your spouse's unmarried dependent child who: (a) is less than 20 years of age, or less than 26 if a full-time student, and (b) depends primarily on *you* or your spouse for support and maintenance.

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

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

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

CGP-3-MDG-DEF-4C

B850.0600

Glossary (Cont.)

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

Glossary (Cont.)

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

COORDINATION OF BENEFITS

Applicability

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

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

As used here:

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

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

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

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

How This Provision Works: The Order of Benefits

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

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

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

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

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

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

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

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

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

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

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

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

How This Provision Works: Coordination of Benefits

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

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

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

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

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

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

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

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

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

For *PCDs'* services:

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

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

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

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

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

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

Our Right To Certain Information

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

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

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STATEMENT OF ERISA RIGHTS

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

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

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

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

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

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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- Review your benefits
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