



YOUR GROUP INSURANCE PLAN BENEFITS

**MCCOY CORPORATION
CLASS 0001
DENTAL**

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.

Have a complaint or need help?

If You have a problem with a claim or Your premium, call Your insurance company first. If You can't work out the issue, the Texas Department of Insurance may be able to help.

Even if You file a complaint with the Texas Department of Insurance, You should also file a complaint or appeal through Your insurance company. If You don't, You may lose Your right to appeal.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

To get information or to file a complaint with your insurance company or HMO:

Call: (toll-free) 1-888-GUARDIAN (1-888-482-7342)

Online: www.guardiananytime.com/contact-us

Email: corporate_inquiries@glic.com

Mail: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call: 1-800-252-3439

Online: www.tdi.texas.gov

E-mail: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714

Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamacion o con su prima de seguro, llame primero a su compania de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en ingles) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, tambien debe presentar una queja a traves del proceso de quejas o de apelaciones de su compania de seguros. Si no lo hace, podria perder su derecho para apelar.

The Guardian Life Insurance Company of America and/or Managed DentalGuard (for DHMO coverage only)

Para obtener informacion o para presentar una queja ante su compania de seguros:

Llame: (telefono gratuito) 1-888-GUARDIAN (1-888-482-7342)

En linea: www.guardiananytime.com/contact-us

Correo electronico: corporate_inquiries@glic.com

Direccion postal: Corporate Complaints, 10 Hudson Yards, New York, NY 10001

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame: 1-800-252-3439

En linea: www.tdi.texas.gov

Correo electronico: ConsumerProtection@tdi.texas.gov

Direccion postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000
www.GuardianAnytime.com

If Your Group Certificate includes any of the following coverages: Guardian Insured: Group Accident, Group Cancer, Group Critical Illness, Group Hospital Indemnity, Group Dental or Group Vision, the following consumer complaint notice is applicable. (Employer Funded Coverages, if any, are excluded from this Rider.)

New Mexico Residents
Consumer Complaint Notice

If You are a resident of New Mexico, Your coverage will be administered in accordance with the minimum applicable standards of New Mexico law. If You have concerns regarding a claim, premium, or other matters relating to this coverage, You may file a complaint with the New Mexico Office of Superintendent of Insurance (OSI) using the complaint form available on the OSI website and found at:

<http://www.osi.stat.nm.us/ConsumerAssistance/index.aspx>

CCN-2019-NM

B999.0042

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

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IMPORTANT NOTICE

The insurance policy under which this certificate is issued is not a policy of Workers' Compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the Workers' Compensation system.

CGP-3-R-COMP-TX-92

B120.0015

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0012

Limitation of Authority

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

CGP-3-R-LOA-90

B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-90

B160.0003

Dental Claims Provisions

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

Dental Claims Provisions (Cont.)

- Notice** You must send us written notice of an *injury* or *sickness* for which a claim is being made within 20 days of the date the *injury* occurs or the *sickness* starts. This notice should include your name and *plan* number. If the claim is being made for one of your *covered dependents*, his or her name should also be noted.
- Proof Of Loss** We'll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don't furnish the forms on time, we'll accept a written description and adequate documentation of the *injury* or *sickness* that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.
- Late Notice Of Proof** We won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.
- Payment Of Benefits** We'll pay all dental benefits to which you're entitled within 60 days after we receive written proof of loss.
- We pay all dental benefits to you, if you're living. If you're not living, we have the right to pay all dental benefits to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services.
- When you file proof of loss, you may direct us, in writing, to pay dental benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can't tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this *plan* to such provider.
- Limitations Of Actions** You can't bring a legal action against this *plan* until 60 days from the date you file proof of loss. And you can't bring legal action against this *plan* after three years from the date you file proof of loss.
- Workers' Compensation** The dental benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

CGP-3-R-AHC-90-TX

B160.0072

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87

B240.0044

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 notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

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

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

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

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

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

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

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

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

B235.0622

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

YOUR CONTINUATION RIGHTS

Important Notice

This section does not apply to coverages which provide benefits for loss of income due to disability. All other coverages under the group plan are affected by this section, and are hereafter referred to as "group coverage."

Continuation of Coverage During a Labor Dispute

If A Work Stoppage Occurs A labor dispute may result in a work stoppage which causes your group coverage to end. If this happens, you have the right to continue your group coverage for yourself during the work stoppage, for up to 6 months.

How To Continue Group Coverage To continue your group coverage you must make timely payment of the total premium, including any portion of the premium your employer was paying before work stopped, to the union representing you. If you fail to pay a premium on time, you waive your right to continue under this section.

The Responsibilities of the Union For your group coverage to continue, the union representing you must do the following:

- (a) collect the premium payments made by you; and
- (b) make timely payment of the collected premiums to us.

If any such union, after timely receipt of your premium, fails to pay us on your behalf, thereby causing your group coverage to end, then such union will be liable to you for your benefits, to the same extent as, in place of, us.

The Premium The premium you must pay for continued group coverage will be at the rate that applies to the class of employees to which you belonged on the day work stopped. But, we have the right to increase this rate by up to 20% of any higher amount approved by the Insurance Commissioner, to allow for increased costs and risks caused by this continued coverage. We may do this at any time during the continuation. Nothing in this section alters our right to change premium rates according to the "Premiums" section of the group plan.

When This Continuation Starts Group coverage continued under this section starts on the day work stopped. But, if a premium that was due before the work stoppage began is unpaid at the time work stopped, then payment of such premium before the next premium due date will be required for this continuation to take effect.

When This Continuation Ends Your continued coverage ends on the first of the following:

- (a) the end of the 6 month continuation period;
- (b) when you enter full-time employment with another employer;
- (c) the day the work stoppage ends;

Continuation of Coverage During a Labor Dispute (Cont.)

- (d) at the end of the period for which the last premium payment is made, if you stop paying premium;
- (e) the date you stop being eligible as defined in the group plan, for reasons other than not meeting "actively at work" or "full-time" requirements.

CGP-3-R-CC-LD-1

B240.0001

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Employee Coverage

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

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

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

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

CGP-3-EC-90-1.0

B489.0122

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

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

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

CGP-3-EC-90-2.0

B489.0070-R

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B489.0738

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

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

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

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

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.

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

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

CGP-3-EC-90-3.0

B449.0727

Dependent Coverage

B200.0271

Eligible Dependents For Dependent Dental Benefits Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

CGP-3-DEP-90-2.0

B489.0480

Adopted Children, Step-Children and Grandchildren An *employee's* "dependent children" include: (a) his or her legally adopted children; (b) his or her grandchildren who are dependents for federal income tax purposes at the time application for coverage of the grandchildren are made; and (c) his or her step-children.

We treat a child as legally adopted from the time the child is placed in the home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued

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

CGP-3-DEP-90-3.0

B489.0483

Dependent Coverage (Cont.)

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B449.0042

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

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

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

CGP-3-DEP-90-5.0

B200.0749

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

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

If you do this within the *enrollment period*, the coverage is scheduled to start on the date you become insured for employee coverage.

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

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

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

CGP-3-DEP-90-6.0

B489.0254

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

CGP-3-DEP-90-7.0

B200.0692

Newborn Children We cover an *employee's* newborn child for dependent benefits, from the moment of birth, if the *employee* is already insured for dependent coverage when the child is born. If the *employee* does not have dependent coverage when the child is born, we cover the newborn child, for dependent benefits, for the first 31 days from the moment of birth. To continue the child's dependent benefits past the first 31 days, the *employee* must notify us in writing within 31 days of the child's birth.

CGP-3-DEP-90-8.0

B489.0178

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

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

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

Dependent Coverage (Cont.)

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this coverage's age limit.

CGP-3-DEP-90-9.0

B489.0920

It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

B489.1153

DENTAL HIGHLIGHTS

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

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

For Group I Services	None
For Group II and III Services	\$50.00

for each covered person

CGP-3-DENT-HL-90 B497.0075

- **Payment Rates:**

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

CGP-3-DENT-HL-90 B497.0086

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

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

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services Up to \$1,000.00

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

CGP-3-DENT-HL-90 B497.1432

Group Enrollment Period

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

CGP-3-DENT-HLTS B497.2407

DENTAL EXPENSE INSURANCE

This insurance will pay many of a *covered person's* dental expenses. *We* pay benefits for covered charges incurred by a *covered person*. What *we* pay and terms for payment are explained below.

CGP-3-DG2000

B498.0007

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in this *plan's* List of Covered Dental Services. To be covered by this *plan*, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

To be covered by this *plan*, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a *dentist* to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, *we* mean the charge is the *dentist's* usual charge for the service furnished. By customary, *we* mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists*. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this *plan*, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the *dentist* submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, *we* may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a *covered person* while he or she is insured by this *plan*. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other *dental prosthesis* is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for *orthodontic treatment* is incurred on the date the *active orthodontic appliance* is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a *covered person* is insured, *we'll* only pay benefits for services which are completed within 31 days of the date his or her coverage under this *plan* ends.

CGP-3-DGY2K-CC-TX

B498.0387

Appeal Process

Definitions

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

- Adverse Determination** This term means a determination by a utilization review agent(URA) that the health care services provided or proposed to be provided to the *covered person* are not *medically necessary* or are experimental or investigational.
- Certification** This term means a determination that the health care services being provided or proposed to be provided to a *covered person* meet the criteria for *medical necessity* and appropriateness.
- Clinical Peer** This term means a *dentist* or health care professional in the same or similar specialty, who typically manages the medical condition, procedure or treatment under review.
- Concurrent Review** This term means a utilization review conducted for a currently in process course of treatment.
- Department** This term means the Texas Department of Insurance.
- Emergency Care** This term means health care services provided in a *hospital* emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson who has an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in: (a) placing a *covered person's* health in serious jeopardy; (b) serious impairment to bodily functions; (c) serious dysfunction of any bodily organ or part; (d) serious disfigurement; or (e) in the case of a pregnant woman, serious jeopardy to the health of the fetus.
- External Review** This term means the review of an adverse determination by an independent review organization(IRO).
- Life-Threatening** This term means a disease or condition for which the likelihood of death is probable unless the course of the disease or condition is interrupted. A life-threatening condition exists if a prudent layperson who has an average knowledge of medicine and health would believe that his or her disease or condition is a life-threatening condition.
- Prospective Review** This term means a utilization review conducted prior to a course of treatment.
- Retrospective Review** This term means the utilization review process of reviewing the medical necessity and reasonableness of health care that has been provided to a *covered person*.

- Utilization Review** This term includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.
- Working Day** This term means a weekday. It excludes: (a) New Years Day; (b) Memorial Day; (c) Fourth of July; (d) Labor Day; (e) Thanksgiving Day; and (f) Christmas Day.

Utilization Review Determinations

When the initial determination is certification, written notification will be sent to a *covered person* and the *covered person's* health care provider within two working days of making the determination.

The URA will make an initial determination in a prospective review within three working days of receipt of all information needed to complete the review.

The URA will make an initial determination in a concurrent review within three working days of receipt of all information needed to complete the review.

The URA will make an initial determination in a retrospective review within thirty days of receipt of all information needed to complete the review. This period may be extended once by the URA for a period not to exceed 15 days, if the URA:

- (a) determines that an extension is necessary due to matters beyond the URA's control; and
- (b) notifies the provider of record and the *covered person* before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the URA expects to make a determination.

If the extension is required because of the failure of the provider of record or the *covered person* to submit information necessary to reach a determination on the request, the notice of extension must:

- (a) specifically describe the required information necessary to complete the request; and
- (b) give the provider of record and the *covered person* at least 45 days from the date of receipt of the notice of extension to provide the specified information.

If the period for making the determination under this section is extended because of the failure of the provider of record or the *covered person* to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the URA sends the notification of the extension to the provider of record or the *covered person* until the earlier of:

Appeal Process (Cont.)

- (a) the date on which the provider of record or the *covered person* responds to the request for additional information; or
- (b) the date by which the specified information was to have been submitted.

Notice of adverse determination will include:

- (1) the principal reasons for the adverse determination;
- (2) the clinical basis for the adverse determination;
- (3) a description of the source of the screening criteria that were used in making the determination;
- (4) a description of the complaint and appeal process; and
- (5) the independent review notification procedures, and the independent review request form.

For life-threatening conditions, notice of adverse determination will be given within the time frames shown above. In circumstances involving a life-threatening condition, the *covered person*, person acting on the *covered person's* behalf, or the *covered person's* provider of record is entitled to immediate external appeal by independent review and is not required to comply with procedures for reconsideration or internal appeals.

CGP-3-DGY2K-APP-TX-10

B498.4839

Internal Appeals

A *covered person*, a person acting on the *covered person's* behalf, or the *covered person's* doctor or health care provider may appeal an adverse determination orally or in writing.

Standard Appeal The request for standard appeal should be made or sent to the URA or to:

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 981573
El Paso, TX 79998-1573

Within five working days from receipt of a written appeal, a letter of acknowledgment will be sent to the appealing party. The letter will include the date the request for appeal was received, and a list of any documentation the appealing party is required to submit to support his or her request.

A licensed *doctor* or *dentist* will review the appeal and render a decision.

Within five working days of receipt of an oral request for standard appeal, an appeal form will be mailed to the appealing party.

A licensed *doctor* or *dentist* will review the appeal and render a decision.

Notification of that decision will be mailed to the *covered person* or a person acting on behalf of the *covered person* and to the *covered person's* health care provider within 30 days of receipt of the request for standard appeal.

If the appeal is denied, the notice will include:

- (1) a statement of the specific reasons for the resolution;
- (2) the clinical basis for such decision;
- (3) the specialization of any *doctor* or other provider consulted; and
- (4) in the case of a denial, notice of the appealing party's right to seek independent review of the denial and the procedure for obtaining that review, including the necessary forms.

If the appeal is denied, the *covered person's* health care provider may request, in writing, a review of the denial by a health care provider in the same or similar specialty as typically manages the condition, procedure, or treatment under review. This request must: (a) be made within ten working days of the denial of the appeal; and (b) set forth good cause for having a particular type of specialty provider review the case. The specialty review will be completed within 15 working days of receipt of the request.

Expedited Appeal If the adverse determination involves emergency care, denial of care for a life-threatening condition, or denial of continued stay for a hospitalized *covered person*, the appealing party may call, write, or fax a request for an expedited appeal to the URA or to:

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 981573
El Paso, TX 79998-1573
Phone: (800) 541-7846
Fax: (509) 468-6123

A licensed *dentist* or licensed health care professional who typically manages the medical/dental condition under review and who did not previously review the case will review the appeal.

A decision will be made within a timeframe appropriate to the medical or dental immediacy of the condition, treatment or procedure under review but in no event later than one working day after receipt of all information required to make the decision.

The *covered person* and the *covered person's* health care provider will be notified by telephone or electronic transmission within one working day of making the decision. Written confirmation will also be sent to the *covered person* or a person acting on behalf of the *covered person*.

If the appeal is denied, the written notification will include:

- (1) a statement of the specific reasons for the resolution;
- (2) the clinical basis for such decision;
- (3) the specialization of any *doctor* or other provider consulted; and
- (4) in the case of a denial, notice of the appealing party's right to seek independent review of the denial and the procedure for obtaining that review, including the necessary forms.

External Appeals

A *covered person*, a person acting on the *covered person's* behalf, or the *covered person's doctor* or health care provider may request an external review of an adverse determination: (a) after the denial of a standard or expedited appeal; or (b) immediately in the case of a life-threatening condition. The request is made by completing the request form and executing the authorization to release medical information and sending them to the URA or to:

The Guardian Life Insurance Company of America
Dental Grievance Department
P.O. Box 981573
El Paso, TX 79998-1573
Phone: (800) 541-7846
Fax: (509) 468-6123

Upon receipt of the request for external review, the Department will be notified of the request. The Department will assign an independent review organization(IRO) within one working day and will notify Guardian and the IRO of the assignment. The Department will notify the *covered person* or a person acting on behalf of the *covered person* and the *covered person's* health care provider within one working day of making the assignment.

Within three working days of receipt of the request for external review, the following information must be sent to the assigned IRO:

- (1) any relevant medical records;
- (2) any relevant portions of the utilization review *plan* used in making the decision;
- (3) a copy of the written notice of the appeal's denial;
- (4) any documentation and written information submitted by the appealing party in support of the appeal; and
- (5) a list of the names, addresses, and phone numbers of each *doctor* or health care provider who has provided care to the *covered person* and who may have medical records relevant to the appeal.

The IRO should review the case and render a decision within the time frames shown below.

- (1) If a life-threatening condition exists, the earlier of: (a) five working days of receipt of all information needed to complete the review; and (b) eight working days of receipt of the request for review.
- (2) If a life-threatening condition does not exist, the earlier of: (a) 15 working days of receipt of all information needed to complete the review; and (b) 20 working days of receipt of the request for review.

Appeal Process (Cont.)

The IRO should notify the *covered person* or person acting on behalf of the *covered person* and the *covered person's* health care provider of the decision.

This *plan* must cover charges for any covered services determined to be *medically necessary* or appropriate by the IRO. And, this *plan* will pay the cost of the external review.

CGP-3-DGY2K-APP-TX-10

B498.9160

Alternate Treatment

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by *us*. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

Proof Of Claim

So that *we* may pay benefits accurately, the *covered person* or his or her *dentist* must provide *us* with information that is acceptable to *us*. This information may, at *our* discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document *proof of claim* and support the necessity of the proposed treatment. If *we* don't receive the necessary information, *we* may pay no benefits, or minimum benefits. However, if *we* receive the necessary information within 15 months of the date of service, *we* will redetermine the *covered person's* benefits based on the new information.

CGP-3-DGY2K-AT

B498.0002

Pre-Treatment Review

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

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

Pre-Treatment Review (Cont.)

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person's dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person's condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

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

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

CGP-3-DGY2K-PTR

B498.0003

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this *plan*. For instance, you may be covered by this *plan* and a similar plan through your spouse's employer. You may also be covered by this *plan* and a medical plan. In such instances, we coordinate *our* benefits with the benefits from that other plan. *We* do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

CGP-3-DGY2K-OS

B498.0005

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN

B498.0072

Penalty For Late Entrants During the first 6 months that a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan*, we won't pay for the following services:

- All Group IV Services.

The Benefit Provision - Qualifying For Benefits (Cont.)

Charges for the services we don't cover under this provision are not considered to be covered charges under this *plan*, and therefore can't be used to meet this *plan's* deductibles.

We don't apply a late entrant penalty to covered charges incurred for services needed solely due to an *injury* suffered by a *covered person* while insured by this *plan*.

A late entrant is a person who: (a) becomes covered by this dental *plan* more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

CGP-3-DGY2K-LE

B498.0231

How We Pay Benefits For Group I, II And III Non-Orthodontic Services

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

A *benefit year* deductible of \$50.00 applies to Group II and III services. Each *covered person* must have covered charges from these service groups which exceed the deductible before we pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Once a *covered person* meets the deductible, we pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year*.

CGP-3-DGY2K-BP-TX

B498.0396

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$1,000.00.

CGP-3-DGY2K-BP

B498.0192

The Benefit Provision - Qualifying For Benefits

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

CGP-3-DG-ROLL-04-2.1

B498.2041

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

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

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

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

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

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

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

- *Rollover Threshold* \$500.00
- *Reward* \$250.00
- *Bank Maximum* \$1,000.00

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

- only claims incurred on or after January 1 will count toward the *Rollover Threshold*; and
- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

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

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

Definitions of terms used in this provision:

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

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

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

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

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

CGP-3-DG-ROLL-04-2-TX

B498.9147

How We Pay Benefits For Group IV Orthodontic Services

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

We pay for Group IV covered charges at the applicable *payment rate*.

Using the *covered person's* original treatment *plan*, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic* appliance is first placed. We make further payments at the end of each month, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan*. We limit what we pay for orthodontic services to the lifetime payment of \$1,000.00. What we pay is based on all of the terms of this *plan*.

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan*. We limit what we pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan*. Based on the original treatment *plan*, we determine the portion of charges incurred by the *covered person* prior to being covered by this *plan*, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment *plan* to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits we pay for *orthodontic treatment* won't be charged against a *covered person's* *benefit year* payment limits that apply to all other services.

CGP-3-DGY2K-OR-MC-TX-14

B498.8810

TMJ and Craniomandibular Disorders

We pay benefits for dental services for the necessary diagnostic and surgical treatment of temporomandibular (TMJ) and craniomandibular joint disorders in a covered person. We cover charges for such conditions as a result of: (1) an accident; (2) a trauma; (3) a congenital defect; (4) a developmental defect; or (5) a pathology.

We treat such services the same way we treat any other covered charges for Group III services.

Subject to the Group III deductible and all other terms of this plan, we pay benefits for such covered charges at a payment rate of 50%. And we won't pay for TMJ or craniomandibular treatment done in the first 24 months a late entrant is insured by this plan.

Under this plan's dental expense provisions, we don't cover any charges for the medical treatment of TMJ.

The Benefit Provision - Qualifying For Benefits (Cont.)

Services listed in this category and related services are covered by your medical carrier and they will be primary. Please submit all claims to the medical carrier first.

CGP-3-DGY2K-TMJ-07

B498.3590-R

Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than three individual *benefit year* deductibles in any *benefit year*. Once this happens, we pay benefits for covered charges incurred by any *covered person* in that *covered family*, at the applicable *payment rate* for the rest of that *benefit year*. The charges must be incurred while the person is insured. What we pay is based on this *plan's payment limits* and to all of the terms of this *plan*.

CGP-3-DGY2K-FL

B498.0073

Payment Rates

Benefits for covered charges are paid at the following *payment rates*:

- Benefits for Group I Services 100%
- Benefits for Group II Services 80%
- Benefits for Group III Services 50%
- Benefits for Group IV Services 50%

CGP-3-DGY2K-PR-TX

B498.0407

After This Insurance Ends

We don't pay for charges incurred after a *covered person's* insurance ends. But, subject to all of the other terms of this *plan*, we'll pay for the following if the procedure is finished in the 31 days after a *covered person's* insurance under this *plan* ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the *covered person's* insurance ends; (b) any other *dental prosthesis*, if the master impression is made before the *covered person's* insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the *covered person's* insurance ends.

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

CGP-3-DGY2K-END

B498.0233

Special Limitations

CGP-3-DGY2K-LMT

B498.0138

If This Plan Replaces The Prior Plan

This *plan* may be replacing the *prior plan* you had with another insurer. If a *covered person* was insured by the *prior plan* and is covered by this *plan* on its effective date, the following provisions apply to such *covered person*.

Special Limitations (Cont.)

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's prosthetic device* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan*; and (b) for which extraction benefits were paid by the *prior plan*.
- **Deductible Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's* deductibles required under this *plan*, by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

CGP-3-DGY2K-PP-MC-TX-14

B498.8811

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation, or inhalation sedation, including but not limited to nitrous oxide. Except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.

Exclusions (Cont.)

- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis*; and (2) facings of a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis*; unless (1) it is at least 5 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services.

Exclusions (Cont.)

- The repair of an orthodontic appliance.
- The replacement of a lost or broken orthodontic retainer.

CGP-3-DGY2K-EXCH-MC-TX-14

B498.8812

List of Covered Dental Services

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

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

CGP-3-DNTL-90-13

B490.0048

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis And Fluorides Prophylaxis - limited to 2 prophylaxis in any 12 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to *covered persons* under age 16 and limited to 2 treatments in any 12 consecutive month period.

Office Visits, Evaluations And Examination Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 2 in any 12 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 2 in a 12 consecutive month period.

After hours office visit and other non-routine, unscheduled visits - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed during the same visit.

CGP-3-DNTL-90-14

B498.4802-R

Group I - Preventive Dental Services (Cont.)

(Non-Orthodontic)

Radiographs Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 36 consecutive month period.

Full mouth series, of at least 14 films including bitewings

Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Extraoral films are limited to two per calendar year.

Other diagnostic radiographs:

Bitewing films - limited to a maximum of 4 bitewing films, in one visit, once in any calendar year.

Intraoral periapical or occlusal films - single films

Oral/facial photographic images, limited to once every 36 consecutive month period.

CGP-3-DNTL-90-14

B498.8740-R

Dental Sealants Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the permanent molar teeth of *covered persons* under age 16 and limited to one treatment, per tooth, in any 36 consecutive month period.

CGP-3-DNTL-90-14

B498.0166-R

Group II - Basic Dental Services

(Non-Orthodontic)

Office Visits, Evaluations And Examination Emergency palliative treatment and other non-routine, unscheduled visits. Covered if no other treatment, other than radiographs, is performed during the same visit.

Diagnostic Services Allowance includes examination and diagnosis.

Consultations - Diagnostic consultation with a dentist other than the one providing treatment, limited to one consultation for each *covered dental specialty* in any 12 consecutive month period. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Diagnostic casts - limited to once in a 24 consecutive month period.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 12 consecutive month period for covered persons age 40 and older.

Group II - Basic Dental Services (Cont.)

(Non-Orthodontic)

Space Maintainers Space Maintainers - limited to *covered persons* under age 16 and limited to initial *appliance* only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, limited to once every 60 consecutive months.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 6 months after the initial insertion

Restorative Services Multiple restorations on one surface will be considered one restoration. Benefits for the replacement of existing amalgam and resin restorations will only be considered for payment if at least 12 months have passed since the previous restoration was placed if the *covered person* is under age 19, and 36 months if the *covered person* is age 19 and older. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

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Non-Surgical Extractions Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth
Root removal non-surgical extraction of exposed roots

Surgical Extractions Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

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

Other Oral Surgical Procedures Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty
Tooth reimplantation
Appliance removal (not by dentist who placed appliance), includes removal of arch bar. Limited to once per lifetime.

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Other Services General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this *plan*.

Injectable antibiotics needed solely for treatment of a dental condition.

Application of desensitizing medicaments.

Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.

Occlusal guards - limited to once in a 36 consecutive month period.

Occlusal relines and repairs are limited to once every 12 months and must be performed more than 6 months after occlusal guard.

CGP-3-DNTL-90-15

B498.0206-R

Group III - Major Dental Services (Non-Orthodontic)

Major Restorative Services Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or *injury*, and only when the tooth cannot be restored with amalgam or composite filling material. Post and cores are covered only when needed due to decay or *injury*. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

Single Crowns

- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Inlays

Onlays, including inlay

Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

Cast post and core in addition to a unit of crown or bridge, per tooth

Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth

Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.

Abutment supported crown

Implant supported crown

Abutment supported retainer for fixed partial denture

Implant supported retainer for fixed partial denture

Implant/abutment supported removable denture for completely edentulous arch

Implant/abutment supported removable denture for partially edentulous arch

Implant/abutment supported fixed denture for completely edentulous arch

Implant/abutment supported fixed denture for partially edentulous arch

Dental implant supported connecting bar

Prefabricated abutment

Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.

Surgical placement of implant body, endosteal implant

Surgical placement, eposteal implant

Surgical placement transosteal implant

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime

Radiographic/surgical implant index - limited to once per arch in a 5 consecutive year period

Repair implant supported prosthesis - must be 6 months after initial placement and limited to once every 12 consecutive month period.

Repair implant abutment - must be 6 months after initial placement and limited to once every 12 consecutive month period.

Implant removal - limited to once every 5 consecutive year period.

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 5 consecutive year period. Stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

Protective restoration.

Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material. Limited to 2 per tooth, per lifetime.

CGP-3-DNTL-90-16

B498.1129-R

Prosthodontic Services Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics

Resin with metal

Porcelain

Porcelain with metal

Full cast metal

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

Dentures - Allowance includes all adjustments and repairs done by the *dentist* furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent *appliance*.

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth

Upper, resin base, including any conventional clasps, rests and teeth

Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Lower, resin base, including any conventional clasps, rests and teeth

Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth

Interim partial denture (stayplate), upper or lower, covered on *anterior teeth* only

Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

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Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay

Crown

Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved. Limited to once every 6 consecutive month period and must be done 12 months after the initial insertion.

Denture repairs, metal

Denture repairs, acrylic

Denture repair, no teeth damaged

Denture repair, replace one or more broken teeth

Replacing one or more broken teeth, no other damage

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

Denture rebase, full or partial denture - limited to once per denture in any 12 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.

Denture relines, full or partial denture - limited to once per denture in any 12 consecutive month period. Denture relines done within 6 months are considered to be part of the denture placement when the relines is done by the *dentist* who furnished the denture. Limited to relines done more than 6 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 12 consecutive months after a denture rebase, denture relines or the initial insertion of the denture. Limited to once every 6 consecutive months.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the *dentist* who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

CGP-3-

B498.0208-R

Endodontic Services Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

Pulp capping, direct

Pulp capping, indirect - includes sedative filling.

Vital pulpotomy, only when root canal therapy is not the definitive treatment

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only coinsurance

Root Canal Treatment

Root canal therapy

Root canal retreatment, limited to once per tooth, per lifetime

Treatment of root canal obstruction, no-surgical access

Incomplete endodontic therapy, inoperable or fractured tooth

Internal root repair of perforation defects

Other Endodontic Services

Apexification, limited to a maximum of three visits

Apicoectomy, limited to once per root, per lifetime

Root amputation, limited to once per root, per lifetime

Retrograde filling, limited to once per root, per lifetime

Hemisection, including any root removal, once per tooth

CGP-3-

B498.0209-R

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

- Periodontal Services** Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.
- Periodontal maintenance procedure - limited to a total of two periodontal maintenance procedures in any 12 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing.
- Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.
- Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.
- The localized delivery of chemotherapeutic agents limited to 3 sites per quadrant or a total of 12 site.
- Provisional splinting.
- Periodontal Surgery** Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.
- The following treatment is limited to a total of one of the following, once per tooth in any 36 consecutive months.
- Gingivectomy, per tooth (less than 3 teeth)
 - Crown lengthening - hard tissue
- The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.
- Gingivectomy or gingivoplasty, per quadrant
 - Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
 - Gingival flap procedure, including scaling and root planing, per quadrant
 - Distal or proximal wedge, not in conjunction with osseous surgery
 - Surgical revision procedure, per tooth
- The following treatment is limited to a total of one of the following, once per area or tooth, every 36 consecutive months.
- Guided tissue regeneration, resorbable barrier or nonresorbable barrier
 - Bone replacement grafts, when the tooth is present
- The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.
- Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

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B498.0211-R

Group IV - Orthodontic Services

Orthodontic Services Any covered Group I, II or III service in connection with *orthodontic treatment*.

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment*, Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment*, including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

Fixed and Removable Appliances - limited to once every 5 consecutive year period. Allowance includes all adjustments in the first 6 months after insertion.

CGP-3-DNTL-90-8

B498.0071-R

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follows when titanium or high noble metal (gold) is used in a *dental prosthesis*.

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a *dental prosthesis*, the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

CERTIFICATE RIDER

This Rider amends this plan to provide additional services as described below.

ADDITIONAL NON-INSURANCE SERVICES

Guardian has arranged to make available, at the policyholder's option, selected services for eligible Guardian policyholders and/or covered persons to receive certain services from third party vendors in addition to the insurance coverage.

The services identified below, and agreed to by the providers of these services, are not provided by Guardian. Guardian receives no fee from the respective vendors to make available the selected services. Further, Guardian will not be liable for the negligent provision of services by third party vendors.

Policyholders and/or covered persons will be provided with complete details about available services and a telephone number to call with questions about the service.

The policyholder and covered persons will be provided the following service(s):

- Comprehensive Employee Assistance (EAP) Services - provides counseling services, legal and financial services, and training resources through telephonic assistance and referrals to local counselors. There is no additional charge above the premium to the covered person for these services.

When this Plan ends, access to the services ends for the Policyholder and for all persons covered under the Plan. When a Policyholder no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the Policyholder and for all persons covered under the Plan.

When a Covered Persons coverage under this Plan ends, access to the service ends for that person. When a Covered Person no longer meets the conditions for eligibility for insurance coverage, access to that service ends for the Covered Person.

Guardian reserves the right to terminate, modify or replace any program at any time. We will give You 60 days advance notice of any service discontinuation.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B531.0789

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

Claim Determination Period This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Definitions (Cont.)

- Coordination Of Benefits** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- Custodial Parent** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- Group-Type Contracts** This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage. If the contract may not be renewed if the insured leaves the employer or organization, it is a group-type contract. If the contract allows for renewal regardless of continued employment or participation in an organization, it is a group-type contract only until the insured leaves the employer or organization.
- Hospital Indemnity Benefits** This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group and group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of \$100.00 per day; (6) medical benefits under group, group-type or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.
- This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of \$100.00 or less per day; (ii) school accident type coverage; or (iii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.
- This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.
- Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.
- Primary Plan** This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

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

This Plan This term means the group health benefits, except prescription drug coverage, if any, provided under this group plan.

CGP-3-R-COB-05

B555.0302

Order Of Benefit Determination

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

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

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

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

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

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

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

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

Order Of Benefit Determination (Cont.)

- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

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

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

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

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

CGP-3-R-COB-05

B555.0303

Effect On The Benefits Of This Plan

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

When This Plan Is Secondary When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

If the primary plan is an HMO and an HMO member has elected to have health care services provided by a non-HMO provider, coordination of benefits will not apply between that plan and this plan.

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

CGP-3-R-COB-05

B555.0304

GLOSSARY

	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS-90	B900.0118
Active Orthodontic	means an <i>appliance</i> , like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.	
	CGP-3-GLOSS-90	B750.0663
Anterior Teeth	means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).	
	CGP-3-GLOSS-90	B750.0664
Appliance	means any dental device other than a <i>dental prosthesis</i> .	
	CGP-3-GLOSS-90	B750.0665
Benefit Year	means a 12 month period which starts on January 1st and ends on December 31st of each year.	
	CGP-3-GLOSS-90	B750.0666
Covered Dental Specialty	means any group of procedures which falls under one of the following categories, whether performed by a specialist <i>dentist</i> or a general <i>dentist</i> : restorative/prosthetic services; endodontic services, periodontic services, oral surgery and pedodontics.	
	CGP-3-GLOSS-90	B750.0667
Covered Family	means an employee and those of his or her dependents who are covered by this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0668
Covered Person	means an employee or any of his or her covered dependents.	
	CGP-3-GLOSS-90	B750.0669
Dental Prosthesis	means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.	
	CGP-3-GLOSS-90	B750.0670
Dentist	means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0671
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

Glossary (Cont.)

Eligible Dependent	is defined in the provision entitled "Dependent Coverage."	
	CGP-3-GLOSS-90	B750.0015
Emergency Treatment	means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0672
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 MCCOY CORPORATION .	
	CGP-3-GLOSS-90	B900.0051
Enrollment Period	with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.	
	CGP-3-GLOSS-90	B900.0004
Full-time	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 37 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
Injury	means all damage to a <i>covered person's</i> mouth due to an accident which occurred while he or she is covered by this <i>plan</i> , and all complications arising from that damage. But the term <i>injury</i> does not include damage to teeth, <i>appliances</i> or <i>dental prostheses</i> which results solely from chewing or biting food or other substances.	
	CGP-3-GLOSS-90	B750.0673
Newly Acquired Dependent	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	
	CGP-3-GLOSS-90	B900.0008
Orthodontic Treatment	means the movement of one or more teeth by the use of <i>active appliances</i> . it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.	
	CGP-3-GLOSS-90	B750.0675

Glossary (Cont.)

Payment Limit	means the maximum amount this <i>plan</i> pays for covered services during either a <i>benefit year</i> or a <i>covered person's</i> lifetime, as applicable.	CGP-3-GLOSS-90	B750.0676
Payment Rate	means the percentage rate that this <i>plan</i> pays for covered services.	CGP-3-GLOSS-90	B750.0677
Posterior Teeth	means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.	CGP-3-GLOSS-90	B750.0679
Plan	means the Guardian group dental plan purchased by the planholder.	CGP-3-GLOSS-90	B750.0678
Prior Plan	means the planholder's plan or policy of group dental insurance which was in force immediately prior to this <i>plan</i> . To be considered a prior plan, this <i>plan</i> must start immediately after the prior coverage ends.	CGP-3-GLOSS-90	B750.0681
Proof Of Claim	means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.	CGP-3-GLOSS-90	B750.0682
We, Us, Our And Guardian	mean The Guardian Life Insurance Company of America.	CGP-3-GLOSS-90	B750.0683-R

The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.

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

B800.0053

The Guardian is located at 10 Hudson Yards, New York, New York 10001.

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

Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

B800.0076

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

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

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

- **Name of Plan:**

MCCOY CORPORATION Plan

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

MCCOY CORPORATION

Address: 1350 IH 35 NORTH
SAN MARCOS TX 78666

Phone Number: 512-395-6644

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**741542718

- **Plan Number:** 501

- **Type of Administration:**contract administration

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

MCCOY CORPORATION

Address: 1350 IH 35 NORTH
SAN MARCOS TX 78666

Phone Number: 512-395-6644

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

MCCOY CORPORATION

Address: 1350 IH 35 NORTH
SAN MARCOS TX 78666

Phone Number: 512-395-6644

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

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.
- **Date of End of Record Year:** January 1st .
- **Sources of Contribution:**Contributions to the plan are provided by:
 - the Employer
 - the Employee
 - Both the Employer and the Employee (assuming there are situations where both contribute).
- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)
- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.
- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.
- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0383

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

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

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

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

Plan Sponsors.Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0051

Guardian is required to use or disclose your PHI :

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

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

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

Other Uses and Disclosures .

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

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.

- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0052

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

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

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

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

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

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

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

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

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

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

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

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

B998.0053

The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY

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

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

How to Contact Us:

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

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055



**The Guardian Life Insurance
Company of America**
10 Hudson Yards
New York, New York 10001

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