YOUR
GROUP INSURANCE
PLAN

KALAMAZOO VALLEY COMMUNITY COLLEGE
CLASS 0001
DENTAL, ACCIDENT BENEFITS

This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

B110.0023

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IMPORTANT NOTICE

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

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

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

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

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

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

B115.0127

SECTION I: Employer-Funded Benefits Not Insured By Guardian

B115.0002

An Important Notice About Continuation Rights

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

B235.0109

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

Under this section, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) 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.

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

B235.0577

All Options

If You Die While Covered

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

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

B235.0181

All Options

Your Employer's Responsibilities

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

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

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

Election of Continuation

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

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

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

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

Grace in Payment

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

When Continuation Ends

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

(1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

(2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

(3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

(4) the date the employer ceases to provide any group health plan to any employee;

(5) the end of the period for which the last payment is made;

(6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

(7) the date, after the date of election, he or she becomes entitled to Medicare.

B235.0190

Uniformed Services Continuation Rights

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

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

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

B235.0194

All Options

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

All Options

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.

B489.0122

All Options

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.

B489.0070

All Options

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason, other than disability. Such reasons include death, retirement, layoff, leave of absence and the end of employment.

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

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

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

B489.0087

All Options

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

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an *employee* who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the *employee* under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other *employee;* or (b) any later 12 month period in the case of an *employee* who cares for a covered servicemember.

- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

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

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

B449.0727

All Options

Dependent Coverage

B200.0271

All Options

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

B489.0460

All Options

Adopted Children And Step-Children

Your "dependent children" include your legally adopted children and, your step-children. We treat a child as legally adopted if the child is in your legal custody under an interim court order of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And we exclude any dependent who is on active duty in any armed force.

B489.0503

All Options

Handicapped Children

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

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

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

The child's coverage ends when yours does.

B449.0042

All Options

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.

B200.0749

All Options

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 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 date you sign the enrollment form.

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

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

B489.0252

All Options

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

B200.0692

All Options

Newborn Children We cover your newborn child for dependent benefits, from the moment of birth, if you are already covered for dependent child coverage when the child is born. If you do not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will end at the end of the 31 days, and once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

B489.0006

All Options

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.

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

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

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

B489.0468-R

All Options

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

B497.0075

Option A

- **Payment Rates:**

For Group I Services 100%
For Group II Services 90%
For Group III Services 70%
For Group IV Services 60%

B497.0086

Option B

- **Payment Rates:**

For Group I Services 60%
For Group II Services 60%
For Group III Services 60%
For Group IV Services 60%

B497.0086

Option A

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

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

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services . . . . . Up to $1,000.00

B497.1770

Option B

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

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

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services . . . . . Up to $500.00

B497.1770

All Options

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.

B497.2407

All Options

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.

B498.0007

All Options

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.

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 95th 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.

B498.0069

APPEALS PROCESS AND GRIEVANCE PROCEDURES FOR DENTAL CARE EXPENSE INSURANCE

Definitions

"Grievance" means a written complaint submitted by a *covered person* or his or her *authorized representative* regarding: (1) the availability, delivery, or quality of *health care services,* including a complaint regarding an *adverse determination* made pursuant to *utilization review;* (2) benefits or claim payment, handling, or reimbursement for *health care services;* or (3) matters pertaining to the contractual relationship between a *covered person* and Guardian.

"Adverse determination" means a determination made by Guardian, or its designated utilization review organization that an admission, availability of care, continued stay, or other *health care service* has been reviewed, and denied, reduced or terminated. Failure to respond in a timely manner to a request for a determination constitutes an *adverse determination.*

When an *adverse determination* is made, Guardian or its designated utilization review organization will provide the *covered person* with a written statement containing the reasons for the *adverse determination* and a written notice of the grievance procedures. If a *covered person* or his or her *authorized representative* does not agree with a determination, he or she may file a *grievance* under: (1) the *plan* 's internal grievance process; and (2) under certain conditions, under the external review process.

"Authorized representative" means any of the following: (1) a person to whom the *covered person* has given express written consent to represent the *covered person* in the grievance process; (2) a person authorized by law to provide substituted consent for a *covered person;* and (3) if the *covered person* is unable to provide consent, a family member of the *covered person* or the *covered person* 's treating health care provider.

"Director" means the *director* of the office of the Department of Insurance and Financial Services (DIFS) of the State of Michigan.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, *injury,* or disease.

"IRO" means an independent review organization, an entity that conducts independent external reviews of *adverse determinations.*

"URO" means a utilization review organization, an entity that conducts *utilization review* (other than Guardian).

"Utilization Review" means a set of formal techniques designed to monitor the use of, evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, *health care services,* procedures, or settings.

B498.9037

Internal Grievance Procedures

The grievance procedures ensure full investigation of a *covered person*'s complaint and provide for timely notification to the *covered person* or his or her *authorized representative* of the progress of the investigation. There are several levels of review available under the internal grievance procedures:

Formal Review

(a) *grievance* may be submitted in writing by the *covered person* or his or her *authorized representative.*

(b) Guardian or its designated *URO* will make a final determination in writing within 35 calendar days after a formal *grievance* is submitted in writing.

(c) The timing of the 35 calendar-day period may be tolled for: (i) any period of time the *covered person* is permitted to take under the grievance procedure; and (ii) for a period not to exceed 10 business days if Guardian or its designated *URO* has not received information requested from a health care provider.

(d) A *covered person* has the right to present a *grievance* before a designated committee of Guardian.

Expedited Review

(a) A *covered person* is entitled to an expedited review when a *grievance* has been submitted in writing; AND a doctor, orally or in writing, certifies that the 35 calendar-day time frame of the formal review process would seriously jeopardize the life or health of the *covered person* or the *covered person* 's ability to regain maximum function.

(b) Guardian or its designated *URO* will make a determination within 72 hours after receiving an expedited *grievance.*

(c) If Guardian or its designated *URO* rendered a determination orally, written confirmation of the determination will be provided to the *covered person* within 2 business days after the oral determination.

External Review

A *covered person* or his or her *authorized representative* may request an external review after having exhausted all levels of the internal grievance process, except as set forth in (a) and (b) below. Written notice of the external review process will be given to the *covered person* at the time he or she is informed of an *adverse determination.* Such notice will:

(a) state that if the *covered person* has a medical condition where the timeframe for completion of the expedited review under the internal grievance procedures would seriously jeopardize the life or health of the *covered person* or the *covered person* 's ability to regain maximum function, as certified by a doctor, either orally or in writing, the *covered person* or his or her *authorized representative* may request an expedited external review and an internal expedited review at the same time.

(b) state that if Guardian or its designated *URO* failed to issue a written decision within the timeframes required under the internal grievance procedures, and the *covered person* or his or her *authorized representative* did not request or agree to a delay, the *covered person* or his or her *authorized representative* may request an external review and will be considered as having exhausted all levels of the internal grievance process.

(c) highlight the *covered person*'s or his or her *authorized representative*'s opportunity to submit additional information.

B498.9038

All Options

(d) include any forms needed to process an external review. The forms will include a health information release form or other form approved by the *director,* which is required for the purposes of conducting the external review; and by which the *covered person* authorizes his or her health care providers and Guardian or its designated *URO* to disclose protected health information, including medical records, that are pertinent to the external review.

Standard External Review

A *covered person* or his or her *authorized representative* may submit a written request to the *director* for an external review within 60 days of the date of receipt of an *adverse determination.*

Upon receipt of the request for external review, the *director* will notify and send a copy of the request to Guardian.

Within 5 business days of receipt of the request for external review, the *director* will complete a preliminary review of the request to determine

(a) if the person was a *covered person* under this *plan* at the time the *health care service* was requested or was provided.

(b) if the *health care service* reasonably appears to be a covered service under this *plan.*

(c) if the *covered person* has exhausted all levels of the internal grievance process, unless not required to do so as set forth above.

(d) if the *covered person* has provided all information and forms required by the *director* to process an external review, including the health information release form.

(e) if the *health care service* appears to involve issues of medical necessity or clinical review criteria.

Upon completion of the preliminary review, the *director* will provide written notice to the *covered person* or his or her *authorized representative* whether the request for external review has been accepted.

If the request is not accepted because the request is not complete, the *director* will inform the *covered person* or his or her *authorized representative* what information or materials are needed to make the request complete. If the request is not accepted for external review, the *director* will provide written notice to the *covered person* or his or her *authorized representative* and to Guardian of the reasons the request was not accepted.

If the request for external review is accepted, the *director* will

(a) provide written notice to the *covered person* or his or her *authorized representative* that the *covered person* or his or her *authorized representative* may submit to the *director,* in writing, within 7 days of receipt of the notice, additional information and supporting documentation to be considered by the assigned *IRO* when conducting the external review. The *director* will forward this information to the *IRO* and to Guardian.

(b) provide written notice to Guardian that the request for external review has been accepted.

If the request for external review is accepted and appears to involve issues of medical necessity or clinical review criteria, the *director* will assign an approved *IRO* to conduct the external review and provide a written recommendation to the *director* whether to uphold or reverse the *adverse determination.*

B498.9039

All Options

If the request for external review is accepted and does not appear to involve issues of medical necessity or clinical review criteria, but appears to involve solely the contractual provisions of this *plan,* the *director* may:

(a) keep the request and conduct his or her own external review; or

(b) assign an approved *IRO* to conduct the external review and provide a written recommendation to the *director* whether to uphold or reverse the *adverse determination.*

If the *director* keeps a request for external review:

(a) he or she will review the request and issue a decision to uphold or reverse the *adverse determination* within 14 days of the decision to keep the request.

(b) he or she will be subject to all the other time frames and requirements applicable to requests assigned to *IRO*s, as set forth below.

(c) he or she will immediately assign an approved *IRO* to conduct the external review if, at any time during the *director's* review of the request, it is determined that the request does appear to involve issues of medical necessity or clinical review criteria.

Within 7 business days of receipt of the written notice that the request for external review has been accepted, Guardian or its designated *URO* must provide to the assigned *IRO* any documents and information considered in making the *adverse determination.* If the *IRO* notifies the *director* that Guardian or its designated *URO* has failed to provide this information within the required time frame, the *director* may end the external review and render a decision to reverse the *adverse determination.* The *director* will immediately notify the *IRO,* the *covered person* or his or her *authorized representative* and Guardian of this decision.

In making its recommendation, the *IRO* will review the following:

(a) all of the documents and information received from Guardian or its designated *URO.*

(b) any information submitted in writing to the *director* by the *covered person* or his or her *authorized representative* and forwarded to the *IRO* by the *director.*

(c) any of the following that are available and which the *IRO* deems appropriate

  (i) any relevant medical records;

  (ii) the treating health care provider's recommendation;

  (iii) consulting reports from appropriate health care professionals and other documents submitted by Guardian, the *covered person* or his or her *authorized representative,* and the treating health care provider;

  (iv) the relevant terms of coverage of this *plan;*

  (v) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines, developed by the federal government; or national or professional medical societies, boards or associations; and

  (vi) any applicable clinical review criteria developed and used by Guardian or its designated *URO.*

In reaching a recommendation, the *IRO* is not bound by any decisions or conclusions reached during Guardian's utilization review process or internal grievance process.

B498.9040

All Options

The *IRO* will provide its recommendation to the *director* within 14 calendar days of the date the *director* accepted the request for external review. The recommendation will include:

(a) a general description of the reason for the request for external review.

(b) the date the *IRO* was assigned by the *director* to conduct the external review.

(c) the date the external review was conducted.

(d) date of the *IRO*'s recommendation.

(e) the principal reason or reasons for its recommendation.

(f) the rationale for its recommendation.

(g) references to the evidence or documentation, including practice guidelines, considered in reaching its recommendation.

Upon receipt of the *IRO* 's recommendation, the *director* will:

(a) review the recommendation to ensure that it is not contrary to the terms of coverage of this *plan.*

(b) provide, within 7 business days of receipt of the *IRO's recommendation, written notice to the covered person* or his or her *authorized representative* and Guardian of the decision to uphold or reverse the *adverse determination.* This notice will include

(i) the principal reason or reasons for the decision, including the information provided by the *IRO.*

(ii) if applicable, the principal reason or reasons why the *director* did not follow the *IRO*'s recommendation.

Upon receipt of notice of a decision to reverse an *adverse determination,* Guardian immediately will approve the coverage that was the subject of the external review.

Expedited External Review

A *covered person* or his or her *authorized representative* may submit a written request to the *director* for an expedited external review within 10 days of the date of receipt of an *adverse determination* if: (1) the *covered person* has a medical condition where the timeframe for completion of the expedited review under the internal grievance procedures would seriously jeopardize the life or health of the *covered person* or the *covered person*'s ability to regain maximum function, as certified by a doctor, either orally or in writing; and (2) the *covered person* or his or her *authorized representative* has requested an internal expedited review. Expedited external reviews are not available for *adverse determinations* of *health care services* that already have been provided to a *covered person.*

Upon receipt of a request for an expedited external review, the *director* will notify and send a copy of the request to Guardian. The *director* will review the request to determine if it is acceptable.

If the request for expedited external review is accepted, the *director* will assign an approved *IRO* to conduct the expedited external review and provide a written recommendation to the *director* whether to uphold or reverse the *adverse determination.* If the *covered person* has not already completed the internal expedited review process, the assigned *IRO* will immediately determine whether the *covered person* will be required to complete the internal expedited review. If the *IRO* determines that the *covered person* must first complete the internal expedited review, the *IRO* will immediately notify the *covered person* or his or her *authorized representative* of that determination and will not proceed with the expedited external review until the internal expedited review is completed.

B498.9041

All Options

Within 12 hours of receipt of the written notice that the request for external review has been accepted, Guardian or its designated *URO* must provide to the assigned *IRO,* by the most expeditious method available, i.e. electronically, or by telephone or facsimile, any documents and information considered in making the *adverse determination.*

In making its recommendation, the *IRO* will review all of the documents and information received from Guardian or its designated *URO* and any of the following that are available and which the *IRO* deems appropriate:

(a) any relevant medical records;

(b) the treating health care provider's recommendation;

(c) consulting reports from appropriate health care professionals and other documents submitted by Guardian, the *covered person* or his or her *authorized representative,* and the treating health care provider;

(d) the relevant terms of coverage of this *plan;*

(e) the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines, developed by the federal government; or national or professional medical societies, boards or associations; and

(f) any applicable clinical review criteria developed and used by Guardian or its designated *URO.*

The *IRO* will provide its recommendation to the *director* as expeditiously as the *covered person*'s medical condition or circumstances require, but not later than 36 hours after the *director* received the request for expedited external review.

Upon receipt of the *IRO*'s recommendation, the *director* will:

(a) review the recommendation to ensure that it is not contrary to the terms of coverage of this *plan.*

(b) provide notice to the *covered person* or his or her *authorized representative* and to Guardian as expeditiously as the *covered person*'s medical condition or circumstances require, but not later than 24 hours after receipt of the *IRO's* recommendation, of the decision to uphold or reverse the *adverse determination.* If the notice was not in writing, written confirmation of the decision will be provided to the *covered person* within 2 business days after the notice was provided and will include:

(i) the principal reason or reasons for the decision, including the information provided by the *IRO.*

(ii) if applicable, the principal reason or reasons why the *director* did not follow the *IRO*'s recommendation.

Upon receipt of notice of a decision to reverse an *adverse determination,* Guardian immediately will approve the coverage that was the subject of the external review.

A *covered person* or the *covered person*'s *authorized representative* may not request another external review of the same *adverse determination* for which an external review decision already has been rendered.

Reconsideration Guardian may reconsider an *adverse determination* that is the subject of an external review. Such reconsideration does not delay or terminate the external review. The external review will only be terminated if Guardian decides, after completing its reconsideration, to reverse its *adverse determination* and to provide the coverage or payment for the *health care service* that was the subject of the external review. Immediately upon making the decision to reverse its *adverse determination,* Guardian will notify the *covered person* or his or her *authorized representative,* the *IRO* and the *director* in writing. The *IRO* will terminate the external review upon receipt of the notice.

B498.9042

Contact Information

To contact Guardian or its designated *URO* regarding *grievances,* the *covered person* or his or her *authorized representative* may write to:

The Guardian Insurance Company of America

Grievance Department

P.O. Box 2457

Spokane, WA 99210-2457

Or

777 W. Magnesium

Spokane, WA 99208-5884

Or

Fax to (509) 468-6399

To contact the *director* regarding *grievances,* the *covered person* or his or her *authorized representative* may write to:

Department of Insurance and Financial Services

Office of General Counsel / PRIRA

PO Box 30220

Lansing, MI 48909-7720

www.michigan.gov/difs

(877) 999-6442 (toll-free)

Maintaining Records

Grievances As required by state law, Guardian will record and maintain summary data on the number and types of *grievances* filed, and will report this data, in the manner specified by the *director,* to the *director* on an annual basis. The data will be reviewed periodically by Guardian's management to assure that appropriate actions have been taken. Copies of all *grievances* and responses will be available at Guardian's principal office for inspection by the Department of Insurance and Financial Services for two years following the year the *grievance* was filed.

External Reviews As required by state law, Guardian will record and maintain summary data on the number and types of requests for external review filed, and will report this data, in the manner specified by the *director,* to the *director* on an annual basis.

B498.9043

All Options

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.

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.

B498.1141

All Options

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.

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.

Pre-Treatment Review (Cont.)

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.

B498.0003

All Options

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.

B498.0005

All Options

The Benefit Provision - Qualifying For Benefits

B498.0072

All Options

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.

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.

B498.0231

All Options

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.*

B498.3656

All Options

All covered charges must be incurred while insured. We limit what we pay each benefit year to $1,500.00. What we pay for Group I Services is not subject to, nor applied toward, the *benefit year payment limit* shown in the schedule but subject to all of the other terms of this plan.

B498.3477

Option A

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 subsequent three month period, 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.

B498.0058

Option B

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 subsequent three month period, 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 $500.00. 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.

B498.0058

All Options

Non-Orthodontic Family Deductible Limit

A *covered family* must meet no more than two 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.*

B498.0073

Option A

Payment Rates

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

- Benefits for Group I Services 100%
- Benefits for Group II Services 90%
- Benefits for Group III Services 70%
- Benefits for Group IV Services 60%

B498.0084

Option B

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

- Benefits for Group I Services 60%
- Benefits for Group II Services 60%
- Benefits for Group III Services 60%
- Benefits for Group IV Services 60%

B498.0084

All Options

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.

B498.0233

All Options

Special Limitations

B498.0138

All Options

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.*

- **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.
- **Orthodontic Payment Limit Credit -** We reduce a *covered person's* orthodontic *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.

B498.0134

All Options

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. This includes, but is 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. This includes 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, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide, except when administered in conjunction with covered services.

- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis;* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.
- 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.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- 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.* But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis;* and (2) odontoplasty.
- Replacing an existing appliance or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 5 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not 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.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- 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; detailed and extensive oral evaluations.
- The repair of an orthodontic *appliance.*
- The replacement of a lost or broken orthodontic retainer.
- Sealants.

B498.2155-R

All Options

List of Covered Dental Services

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

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

B490.0048

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 2 prophylaxis or periodontal maintenance procedures (considered under "Periodontal Services") in a calendar year. 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 19 and limited to 2 treatment(s) in a calendar year.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 2 in a calendar year.

Emergency or problem focused oral evaluation. -

After hours office visit or emergency palliative treatment and other non-routine, unscheduled visits.

B498.9032-R

All Options

Space Maintainers

Space Maintainers - limited to *covered persons* under age 25. Covered only when necessary to replace prematurely lost or extracted deciduous teeth.

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

Recementation of space maintainer performed more than 12 months after the initial insertion

Fixed And Removable Appliances

Fixed and Removable Appliances To Inhibit Thumbsucking - limited to *covered persons* under age 14 and limited to initial *appliance* only. Allowance includes all adjustments in the first 6 months after insertion.

B498.0164-R

All Options

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.

Other diagnostic radiographs:

Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, two per calendar year.

Intraoral periapical or occlusal films - single films

Diagnostic Services

Bacteriologic cultures.

B498.8740-R

B498.0167

All Options

Group II - Basic Dental Services
(Non-Orthodontic)

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 - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

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

Restorative Services

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

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

Stainless steel crown, prefabricated resin crown, and resin based composite crown - Temporary and provisional crowns are considered to be part of the permanent restoration.

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

B498.2781-R

All Options

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.

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

Denture rebase, full or partial denture.

Denture reline, full or partial denture.

Denture adjustments - Denture adjustments done within 6 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 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

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.

B498.1122-R

All Options

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
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

B498.0201

All Options

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 - Allowance includes periodontal pocket charting, scaling and polishing.

Scaling and root planing, per quadrant - 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.

B498.0202-R

All Options

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.

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

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

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.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier
Bone replacement grafts, when the tooth is present

Periodontal surgery related

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, covered only when done within a 6 consecutive month period after osseous surgery, and limited to one per lifetime

B498.0203-R

All Options

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

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

B498.1124

All Options

Other Services

General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered services.

Injectable antibiotics needed solely for treatment of a dental condition.

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. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. 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

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 any 24 month period
Repair implant supported prosthesis
Repair implant abutment
Implant removal

B498.1148

All Options

Prosthodontic Services

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

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
3/4 cast metal crowns
3/4 porcelain crowns

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

B498.1146

All Options

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.

B498.0071

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of the 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 Major Restorative Services are modified to provide that titanium or high noble metal (gold) is covered when used in a *dental prosthesis.*

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.

B531.0025

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 Major Restorative Services and Prosthodontic Services are modified to provide that Porcelain is covered for *anterior* and *posterior teeth.*

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.

B531.0027

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 Exclusions are modified so that we will not pay for any service provided solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) bleaching of discolored teeth; and (3) odontoplasty.

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.

B531.0033

COORDINATION OF BENEFITS

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

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

Definitions

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

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

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

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

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

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

Closed Panel Plan This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

Coordination Of Benefits This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

Custodial Parent This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Group-Type Contracts This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.

Hospital Indemnity Benefits This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of $200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; (6) medical benefits under group or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of $200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

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

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

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

B550.0087

All Options

Order Of Benefit Determination

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

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

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

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

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

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

Child Covered Under More Than One Plan

The order of benefit determination when a child is covered by more than one plan is:

(1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

(2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

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

Active Or Inactive Employee

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

Continuation Coverage

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

Length Of Coverage

The plan that covered the person longer is primary.

Other

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

B550.0088

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.

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

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

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

B550.0089

SUBROGATION AND RIGHT OF RECOVERY

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

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

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

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

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

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

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

Lien Rights This plan will have a lien to the extent of benefits this plan paid due to the covered person's injury, sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or otherwise, including from any insurance coverage, that a covered person receives due to his or her injury, sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by this plan. This includes, but is not limited to: (a) the covered person; (b) the covered person's representative or agent; (c) the third party; (d) the third party's insurer, representative or agent; and (e) any other source who holds such funds.

First Priority Claim This plan's recovery rights are a first priority claim against all third parties or insurance coverage and are to be paid to the plan before any other claim for the covered person's damages. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. This plan will be entitled to full repayment on a first dollar basis from any third party's or insurance coverage's payments, even if such payment to the plan will result in a recovery to the covered person which is not sufficient: (i) to make him or her whole; or (ii) to compensate him or her in part or in whole for the damages sustained. This plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue his or her damage claim.

Applicable To All Settlements And Judgements This plan is entitled to full recovery regardless of whether: (a) any liability for payment is admitted by a third party; or (b) the settlement or judgement received by the covered person identifies the benefits the plan paid. This plan is entitled to recover from any and all settlements or judgements, even those designated as: (i) pain and suffering; or (ii) non-economic damages only.

Cooperation The covered person must fully cooperate with this plan's efforts to recover the benefits it paid. He or she must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his or her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, sickness or condition sustained by him or her. He or she, and his or her agents, must provide all information requested by the plan or its representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as the plan or its representative may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against him or her.

The covered person must do nothing: (a) to prejudice this plan's rights as described in this section; or (b) to prejudice the plan's ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this plan. Failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery obtained by the covered person may result in the termination of benefits or the instigation of legal action against him or her.

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

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

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

B600.0012

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

B900.0118

All Options

Active Orthodontic means an *appliance,* like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

B750.0663

All Options

Anterior Teeth means the incisor and cuspid teeth. The teeth are located in front of the bicuspids (pre-molars).

B750.0664

All Options

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

B750.0665

All Options

Benefit Year means a 12 month period which starts on January 1st and ends on December 31st of each year.

B750.0666

All Options

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist *dentist* or a general *dentist:* restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

B750.0667

All Options

Covered Family means an employee and those of his or her dependents who are covered by this *plan.*

B750.0668

All Options

Covered Person means an employee or any of his or her covered dependents.

B750.0669

All Options

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.

B750.0670

All Options

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 *plan.*

B750.0671

All Options

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

B900.0003

All Options

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

B750.0015

All Options

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 *plan.*

B750.0672

All Options

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

B750.0006

All Options

Employer means KALAMAZOO VALLEY COMMUNITY COLLEGE .

B900.0051

All Options

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

B900.0004

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

B750.0229

All Options

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents,* but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents.*

B900.0006

All Options

Injury means all damage to a *covered person's* mouth due to an accident which occurred while he or she is covered by this *plan,* and all complications arising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *dental prostheses* which results solely from chewing or biting food or other substances.

B750.0673

All Options

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

B900.0008

All Options

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* 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.

B750.0675

All Options

Payment Limit means the maximum amount this *plan* pays for covered services during either a *benefit year* or a *covered person's* lifetime, as applicable.

B750.0676

All Options

Payment Rate means the percentage rate that this *plan* pays for covered services.

B750.0677

All Options

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

B750.0679

All Options

Plan means the Guardian group dental plan purchased by the planholder.

B750.0678

All Options

Prior Plan means the planholder's plan or policy of group dental insurance which was in force immediately prior to this *plan.* To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

B750.0681

All Options

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

B750.0682

All Options

We, Us, Our And Guardian mean The Guardian Life Insurance Company of America.

B750.0683

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.

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

All Options

The Guardian's Responsibilities

B800.0048

All Options

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

B800.0064

All Options

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

B800.0049

Group Health Benefits Claims Procedure

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

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

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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.

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0081

Termination of This Group Plan

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

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

B800.0068

SECTION II: Guardian Insurance

B115.0003

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90 B160.0002

Limitation of Authority

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

CGP-3-R-LOA-90 B160.0004

All Options

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

All Options

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

All Options

Accident and Health Claims Provisions

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

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

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

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

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

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

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

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

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

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

All Options

ELIGIBILITY FOR ACCIDENT INSURANCE

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.

CGP-3-EC-90-1.0 B476.1228

All Options

When Your Coverage Starts Employee benefits are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But you must be actively at work on a *full-time* basis on 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 any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you return to active *full-time* work.

Sometimes, the effective date shown on the sticker or in the endorsement 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-90-6.0 B476.1230

All Options

When Your Coverage Ends *Your* coverage ends on the date *your* active *full-time* service ends for Any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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.

Your coverage ends on the date *you* are no longer working in the United States or working outside the United States for a United States based *employer* in a country or region approved by *us.*

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.

Group Accident Insurance Coverage During a Family Leave of Absence

This section may not apply to an employer's *plan. You* must contact *your* employer to find out if:

- the employer must allow for a leave of absence under Federal law, in which case;
- the section applies to *you.*

Group Accident Insurance may normally end for *you* because *you* cease work due to an approved leave of absence. But, *you* may continue *your* coverage if the leave of absence has been granted: (a) to allow the *you* to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to *your* own serious health condition; or (d) because of any serious injury or illness arising out of the fact that *your* spouse, child, parent, or next of kin, who is a covered service member, 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. *You* will be required to pay the same share of the premium as *you* paid before the leave of absence.

Group Accident Insurance may continue until the earliest of the following:

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

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

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

Contingency Operation: This term means a military operation that: (a) Is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

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.

All Options

Dependent Coverage

CGP-3-DEP-90-1.0 B473.0009

All Options

Eligible Dependents For Dependent Accident Coverage

Your eligible dependents are: (1) *your* legal spouse; And (2) *your* unmarried dependent children from birth until they reach age 26.

CGP-3-DEP-90-2.0 B476.1242

All Options

Adopted Children And Step-Children

Your "unmarried dependent children" include: (a) *your* legally adopted children; and (b) if they depend on *you* for most of their support and maintenance, *your* step-children.

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

Dependents Not Eligible

We exclude any dependent who is insured by this *plan* as an *employee.* And, *we* exclude any dependent who is on active duty in any armed force. Upon notice of entry into service, pro rata unearned premiums will be refunded.

A child may be an eligible dependent of more than one *employee* who is insured under this *plan.* In that case, the child may be insured for dependent accident benefits by only one *employee* at a time.

CGP-3-DEP-90-3.0 B476.1244

All Options

When Dependent Coverage Starts

In order for *your* dependent coverage to start, *you* must: (a) already be insured for *employee* coverage; or (b) enroll for *employee* and dependent coverage at the same time.

Subject to all of the terms of this *plan,* the date *your* dependent coverage is scheduled to start depends on when *you* elect to enroll *your* initial dependents and agree to make the required payments.

If *you* do this on or before *your* eligibility date, the dependent coverage is scheduled to start on the later of: (a) *your* eligibility date; and (b) the date *you* become insured for *employee* coverage.

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

Once *you* have dependent child coverage for *your* initial dependent child(ren), any *newly acquired dependent* children will be covered as of the date they are eligible.

CGP-3-DEP-90-6.0 B476.1247

All Options

Exception *We* will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more activities of daily living. In that case, *we* will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more activities of daily living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

CGP-3-DEP-90-7.0 B476.1248

All Options

When Dependent Coverage Ends Dependent coverage ends for all of *your* dependents when *your* coverage ends. 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 for all *employees* or for an *employee's* class.

If *you* are required to pay part or all of the cost or 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: (a) at 12:01 A.M. Standard Time at the child s place of residence on the date the child attains this *plan s* age limit; (b) when the child marries; or (c) when a step-child is no longer dependent on *you* for most of his or her support and maintenance. This happens to a spouse when a marriage ends in legal divorce or annulment.

CGP-3-DEP-90-7.0 B476.1250

Schedule of Benefits

Employee And Dependent Accident Coverage

For limitations regarding the number of benefit payments per covered accident please refer to the BENEFIT section.

Benefits	
Accident Emergency Room Treatment	$150.00
Accident Follow-Up Visit - Doctor	$25 up to 6 treatments
Accidental Death	Employee: $10,000.00 Spouse: $5,000.00 Child: $5,000.00
Accidental Death Common Carrier	200% of the Accidental Death benefit
Accidental Death Common Disaster	200% of the spouse's Accidental Death benefit
Accidental Dismemberment	Limit for all losses due to same accident: $10,000.00 Loss of a hand, foot or sight: 50% of Accidental Death benefit Multiple Losses of hand, foot or sight: For more than one covered loss due to the same Accident, we will pay 100% of the Accidental Death benefit Loss of thumb and index finger of same hand or Loss of four fingers of same hand: 25% of Accidental Death benefit Loss of all toes of same foot: 25% of Accidental Death benefit
Accidental Death Seatbelt & Airbag benefit	Seatbelt: $10,000.00 Seatbelt & Airbag: $15,000.00
Air Ambulance	$500.00
Ambulance	$100.00
Appliance	$100.00
Blood/Plasma/ Platelets	$300.00

Burn	2nd Degree 18 to 35 square inches: $1,000.00 over 35: $3,000.00 3rd degree 9 to 18 square inches: $2,000.00 18 to 35 square inches: $4,000.00 over 35: $12,000.00
Burn - Skin Graft	50% of burn benefit
Catastrophic Loss	Quadriplegia: 100% of Accidental Death Loss of speech and Hearing (both ears): 100% of Accidental Death Loss of cognitive function: 100% of Accidental Death Hemiplegia: 50% of Accidental Death Paraplegia: 50% of Accidental Death
Child Organized Sport	Additional 20% of payable benefits
Coma	$7,500.00
Concussions	$50.00
Dislocations	Closed/Open
Hip	$1,800.00/$3,600.00
Knee	$900.00/$1,800.00
Shoulder	$270.00/$540.00
Collar bone (sternoclavicular)	$450.00/$900.00
Collar bone (acromioclavicular and separation)	$90.00/$180.00
Ankle or foot	$720.00/$1,440.00
Lower jaw	$270.00/$540.00
Wrist or elbow	$270.00/$540.00
Toe or finger	$90.00/$180.00
Bones of the hand	$270.00/$540.00
Diagnostic Exam (Major)	$100.00
Emergency Dental Work	Crown: $200.00 Extraction: $50.00
Epidural Anesthesia Pain Management	$100.00
Eye Injury	$200.00
Family Care	$20.00 per day
Fracture	Closed/Open
Skull (depressed)	$2,250.00/$4,500.00
Skull (non-depressed)	$900.00/$1,800.00

Hip, Thigh (femur)	$1,350.00/$2,700.00
Vertebrae, body of (excluding vertebrae processes)	$675.00/$1,350.00
Pelvis	$675.00/$1,350.00
Leg	$675.00/$1,350.00
Bones of the face or nose	$315.00/$630.00
Upper jaw, maxilla	$315.00/$630.00
Upper arm (humerous)	$315.00/$630.00
Lower jaw, mandible	$270.00/$540.00
Shoulder blade	$270.00/$540.00
Vertebral process	$270.00/$540.00
Forearm	$270.00/$540.00
Kneecap	$270.00/$540.00
Foot (except toes)	$270.00/$540.00
Ankle	$270.00/$540.00
Rib	$225.00/$450.00
Coccyx	$180.00/$360.00
Finger, toe	$90.00/$180.00
Hospital Admission	$750.00
Hospital Confinement	$175.00 per day
Hospital ICU Admission	$1,500.00
Hospital ICU Confinement	$350.00 per day
Initial Physician's office/Urgent care facility treatment	$50.00
Knee Cartilage	$500.00
Joint Replacement	Hip: $1,500.00 Knee: $750.00 Shoulder: $750.00
Laceration	No sutures required: $20.00 Lacerations less than 5 cm: $40.00 Lacerations at least 5 cm but less than 15 cm: $150.00 Lacerations at least 15 cm or more: $300.00
Lodging	$100.00 per day
Occupational or Physical Therapy	$25 per day
Prosthetic Device/Artificial Limb	1: $500.00 2 or more: $1,000.00
Reasonable Accomodation to Home or Vehicle	$2,500.00

Rehabilitation Unit Confinement		$150.00 per day
Ruptured Disc With Surgical Repair		$500.00
Surgery	Cranial, open-abdominal or thoracic:	$1,000.00 Hernia $125.00
Surgery - Exploratory or Arthroscopic		$150.00
Tendon/Ligament/Rotator Cuff		1: $250.00 2 or more: $500.00
Transportation		$400.00
X - Ray		$20.00

ACCIDENT COVERAGE

Subject to all of this *plan's* terms, this *plan* will pay the benefits described below if a *covered person* sustains an injury or incurs a loss as a result of a covered accident which occurs on or after the date he or she becomes insured by this *plan.* This *plan* pays no benefits other than what is specifically listed below.

All terms in italics are defined terms with special meanings. See the "Definitions" section of this plan. Other terms with special meanings are defined where they are used.

CGP-3-AC-IC-12 B476.0002

All Options

Benefits

Accident Emergency Room Treatment *We* pay the amount shown in the Schedule of Insurance if a *covered person* is examined or treated by a doctor in a *hospital emergency room* for the initial treatment of injuries sustained in a *covered accident* within 72 hours after the *covered accident.* This benefit is payable once per *covered person* per *covered accident. We* will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility benefit for the same *covered accident.*

Accident Follow-Up Visit *We* pay the amount shown in the Schedule of Insurance if a *covered person* requires additional follow up treatments (not including occupational, speech or *physical therapy* or chiropractic treatment) after initial *emergency room* treatment or *doctor's* office/*urgent care facility* treatment. *We* pay up to 6 treatments per *covered person* per *covered accident.* Treatment must begin within 60 days of a *covered accident* and be completed within 365 days.

Accidental Death *We* pay the amount shown in the Schedule of Insurance if a *covered person* sustains an *injury* in a *covered accident* that causes his or her death. The *injury* must cause his or her death within 90 days of the *covered accident.* If *we* pay this benefit, *we* will not pay the Accidental Death Common Carrier benefit.

Accidental Death Common Carrier *We* pay the amount shown in the Schedule of Insurance if a *covered person's accidental death* is due to a *covered accident* which occurs while the *covered person* is riding as a fare-paying passenger in a public conveyance. If *we* pay this benefit, *we* will not pay the Accidental Death benefit.

Accidental Death Common Disaster *We* pay the increased amount shown in the Schedule of Insurance if both *you* and *your* insured spouse die in a *covered accident* or in separate *covered accidents* within the same 24 hour period. The benefit increase applies to *your* insured spouse's benefit.

Accidental Dismemberment *We* pay the amount shown in the Schedule of Insurance if a listed loss is sustained by a *covered person* due to injuries caused by a *covered accident.*

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand. This benefit is not payable if benefits have been paid for "Loss of hand".
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint. This benefit is not payable if benefits have been paid for "Loss of foot".

We will not pay more than $10,000.00 for all losses due to the same *covered accident.*

Accidental Death Seatbelt and Airbag benefit

We pay the seatbelt amount shown in the Schedule of Insurance if a *covered person* dies due to injuries sustained in a *covered accident* while properly wearing a seatbelt. *We* will pay the Seatbelt and Airbag amount shown in the Schedule of Insurance if a *covered person* dies as a direct result of an automobile *accident* while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag. *We* will not pay both the Seatbelt and Seatbelt and Airbag benefit for the same *covered accident.*

Air Ambulance

We pay the amount shown on the Schedule of Insurance if a *covered person* is transported by air ambulance to or from a *hospital* or between medical facilities for treatment of injuries sustained as the result of a *covered accident* within 48 hours of a *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Ambulance

We pay the amount shown on the Schedule of Insurance if a licensed ambulance company transports a *covered person* by ground to or from a *hospital* or between medical facilities for treatment of injuries sustained as a result of a *covered accident* within 90 days of *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Appliance

We pay the amount shown on the Schedule of Insurance if a covered person uses an *appliance* prescribed by a *doctor* as necessary due to an *injury* sustained as a result of a *covered accident.* An *appliance* includes wheelchairs, leg or back braces, crutches, walkers, walking boot that extends above the ankle, and brace for the neck. Use of the *appliance* must begin within 90 days of *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Blood/Plasma/ Platelets

We pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* receives a transfusion, administration, cross matching, typing and processing of blood/plasma/platelets within 90 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Burn *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives burns as a result of a *covered accident* and is treated by a *doctor* within 72 hours of the *covered accident.* If a *covered person* meets more than one of the burn classifications, *we* pay the higher amount. This benefit is payable once per *covered person* per *covered accident.*

Burn - Skin Graft *We* pay the amount shown in the Schedule of Insurance when medically necessary grafting of the skin is received by a *covered person* for a burn that was payable under the Burn benefit. This benefit is payable once per *covered person* per *covered accident.*

Catastrophic Loss *We* pay the amount shown in the Schedule of Insurance if a *covered person* suffers a catastrophic loss within 365 days of a *covered accident* due to injuries sustained in a *covered accident.* This benefit is payable once per *covered person* per *covered accident.* If a Catastrophic Loss benefit is paid, an Accidental Dismemberment benefit will not be paid for the same or attached body part.

CGP-3-AC-BEN-12 B476.0003

All Options

Child Organized Sport *We* pay the additional amount shown on the Schedule of Insurance if the *covered accident* occurred while an *employee's* covered dependent child is participating in an *organized sport.* The child must be insured by this plan on the date the *accident* occurred. The covered child must be 18 years of age or younger.

Coma *We* pay the amount shown in the Schedule of Insurance if as the result of a *covered accident* a *covered person* is in a *coma* lasting at least 7 consecutive days characterized by the absence of eye opening, verbal response, and motor response. The condition must require intubation for respiratory assistance, be diagnosed or treated by a *doctor* within 90 days of the *covered accident.* This benefit is not payable for a medically induced *coma.*

Concussions *We* pay the amount shown in the Schedule of Insurance if a *covered person* sustains a concussion as the result of a *covered accident* and is diagnosed within 72 hours of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Dislocations *We* pay the amount shown in the Schedule of Insurance if a *covered person* is injured and suffers a *dislocation* as the result of a *covered accident.* A *dislocation* must be diagnosed by a *doctor* within 90 days of the *covered accident.* The *dislocation* must be corrected by open (surgical) or closed (non-surgical) reduction.

For multiple *dislocations* due to the same *covered accident,we* will pay no more than two times the benefit amount for the joint involved with the highest benefit amount.

For partial *dislocations, we* will pay 25% of the benefit shown in the Schedule of Insurance for a closed reduction.

Diagnostic Exam (Major) *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives one of the following imaging studies due to a *covered accident* Computerized Tomography (CT scan), computerized axial tomography (CAT), magnetic resonance imaging (MRI or electroencephalography (EEG). The imaging study must be prescribed by a *doctor* and performed in a *doctor's* office or in a *hospital* on an *inpatient* or *outpatient* basis. This benefit is payable once per *covered person* per *covered accident.*

Emergency Dental Work *We* pay the amount shown in the Schedule of Insurance if a *covered person* suffers a broken tooth as the result of a *covered accident* and it is repaired by a *dentist* with a dental crown and/or dental extraction. The dental services must begin within 60 days of the *covered accident.* One dental crown and one dental extraction is payable per *covered person* per *accident.*

Epidural Anesthesia Pain Management *We* pay the amount shown in the Schedule of Insurance if a *covered person* is prescribed and receives an epidural administered for pain management for injuries received as a result of a *covered accident.* The epidural must be administered in a *hospital* or *doctor's* office and is payable twice per covered person per *accident.* This benefit is not payable for an epidural administered during a surgical procedure.

Eye Injury *We* pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and suffers an eye *injury.* They eye *injury* must require surgery or the removal of a foreign object by a *doctor* within 90 days of a *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Family Care *We* pay the amount shown in the Schedule of Insurance if a *covered person* is injured as the result of a *covered accident* and is confined in a *hospital,* ICU or *alternate care* or *rehabilitative facility* and an *employee* has a child or children attending a *child care center.* The benefit is payable for each child attending a *child care center* while the *covered person* is confined. The child attending the *child care center* does not need to be insured under this Policy for Accident coverage but must meet the eligibility requirements found in the Dependent Eligibility section. This benefit is payable for up to 30 days within 365 days of the *covered accident.* This benefit is payable once per child per *covered accident.*

Fracture (Bone) *We* pay the amount shown in the Schedule of Insurance if a *covered person* suffers a *fracture* as a result of a *covered accident* and it is diagnosed within 90 days of the *covered accident.* The *fracture* must require open (surgical) or closed (non-surgical) reduction by a *doctor.* This benefit is payable for up to two *fractures* per *covered person* per *covered accident.* If there are more than two *fractures, we* will pay the highest two benefit amounts per *covered person* per *covered accident. We* pay 25% of the amount shown in the Schedule of Insurance for the closed reduction of a bone with a chip *fracture* that was a result of a *covered accident.*

All Options

Hospital Admission *We* pay the amount shown in the Schedule of Insurance if a *covered person* is admitted to a *hospital* within 180 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable once per *covered person* per *covered accident.* This benefit is not payable for *emergency room* treatment, *outpatient treatment,* or a *hospital* stay less than 20 hours in an observation unit. *We* will not pay the Hospital Admission and Hospital Intensive Care Unit Admission benefits for the same *covered accident.*

Hospital Confinement *We* pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital* within 180 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable up to 365 days per *covered accident.* This benefit is not payable for a *hospital* stay less than 20 hours. *We* pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement benefits for each day.

Hospital Intensive Care Unit Admission *We* pay the amount shown in the Schedule of Insurance if a *covered person* is admitted directly to a *hospital intensive care unit* within 30 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable once per *covered person* per *covered accident.* This benefit is not payable for *emergency room* treatment, *outpatient treatment,* or a *hospital* stay less than 20 hours in an observation unit. *We* will not pay the Hospital Admission and the Hospital Intensive Care Unit Admission benefits for the same *covered accident.*

Hospital Intensive Care Unit Confinement *We* pay the amount shown in the Schedule of Insurance if a *covered person* is confined to a *hospital intensive care unit* within 30 days of a *covered accident* as a result of injuries sustained in a *covered accident.* This benefit is payable up to 15 days per *covered accident.* This benefit is not payable for a *hospital intensive care unit* stay less than 20 hours. *We* pay either the Hospital Confinement or the Hospital Intensive Care Unit Confinement for each day.

Initial Doctor's Office/Urgent Care Facility Treatment *We* pay the amount shown in the Schedule of Insurance if a covered person is examined or treated by a *doctor* in a *doctor's* office or *urgent care facility* for the initial treatment of a *covered accident* within 30 days after the *covered accident.* This benefit is payable once per *covered person* per *covered accident. We* will not pay the Accident Emergency Room Treatment benefit and the Initial Doctor's Office/Urgent Care Facility Treatment benefit for the same *covered accident.*

Knee Cartilage *We* pay the amount shown in the Schedule of Insurance if a *covered person* tears, ruptures or severs knee cartilage (meniscus) as the result of a *covered accident* and requires surgical repair. The *injury* must be treated by a *doctor* within 60 days after the *covered accident* and repaired through surgery within 365 days.

Joint Replacement *We* pay the amount shown in the Schedule of Insurance if due to an *injury* sustained in a *covered accident* a *covered person* requires a hip, knee, or shoulder joint replacement. The joint replacement must be performed by a *doctor* within 90 days of a *covered accident* and is payable once per *covered person* per *covered accident.*

Laceration *We* pay the amount shown in the Schedule of Insurance if a *covered person* sustains a laceration as a result of a *covered accident* and it is repaired by a *doctor* within 72 hours of the *covered accident.* The amount *we* pay will be based on the total length of all lacerations received in any one covered accident which require repair. This benefit is payable once per *covered person* per *covered accident* for a laceration with no sutures and once per *covered person* per *covered accident* for a laceration which required sutures.

Lodging *We* pay the amount shown in the Schedule of Insurance for a *companion's* hotel/motel stay during the period of time a *covered person* is confined to the *hospital* as the result of a *covered accident.* This benefit is payable up to 30 days per *covered person* per *covered accident* and is only payable while the insured is confined to the *hospital.* The *hospital* must be more than 50 miles from the residence of the covered person.

Occupational or Physical Therapy *We* pay the amount shown in the Schedule of Insurance if a *covered person* requires occupational or *physical therapy* due to injuries sustained in a *covered accident.* Treatment must begin within 60 days of the *covered accident,* be completed within 6 months, and be performed by a licensed *occupational* or *physical therapist.* This benefit is payable up to 10 treatments per *covered person* per *covered accident.*

Prosthetic Device/Artificial Limb *We* pay the amount shown in the Schedule of Insurance if due to injuries sustained in a *covered accident* a *covered person* receives one or more prosthetic devices/artificial limbs as prescribed by a *doctor* for functional use due to the loss of a hand, foot or sight of an eye. The device or limb must be prescribed within 365 days of the *covered accident* and is payable once per *covered person* per *covered accident.* This benefit is not payable for hearing aids, dental aids (including false teeth), eyeglasses, or cosmetic prostheses such as hair wigs.

Reasonable Accommodation to Home or Vehicle *We* pay the amount shown in the Schedule of Insurance for a required modification made to a *covered person's* place of residence or vehicle if the *covered person* suffers an Accidental Dismemberment or Catastrophic Loss due to a *covered accident.* The modification must be made within two years of the *covered accident* and is payable once per *covered person* per *covered accident.*

Rehabilitation Unit Confinement *We* pay the amount shown in the Schedule of Insurance if a *covered person* is confined to rehabilitation unit due to injuries sustained in a *covered accident.* This benefit is payable up to 15 days per *covered person* per *covered accident* but cannot exceed 30 days per calendar year. *We* will not pay the Rehabilitation Unit Confinement and the Hospital Confinement benefits for the same day.

Ruptured Disc With Surgical Repair *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives a ruptured disc in his spine as a result of injuries sustained in a *covered accident.* The *injury* must be treated by a *doctor* within 60 days of the *covered accident* and surgically repaired within 365 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

All Options

Surgery (cranial, open-abdominal, thoracic, hernia) *We* pay the amount shown in the Schedule of Insurance if a *covered person* undergoes cranial, open-abdominal, thoracic, or hernia surgery due injuries sustained to a *covered accident.* Cranial, open-abdominal, and thoracic surgery must be performed within 72 hours of the *covered accident.* Hernia surgery must be diagnosed within 30 days of *covered accident* and surgery must be performed within 60 days. If more than one surgery is performed, *we* pay the benefit with the highest dollar amount. This benefit is payable once per *covered person* per *covered accident.*

Surgery (Exploratory and Arthroscopic) *We* pay the amount shown in the Schedule of Insurance if a *covered person* undergoes exploratory or arthroscopic surgery as a result of injuries sustained in a *covered accident* and the surgery takes place within 60 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.* Hernia repair is not covered under this benefit. This benefit is not payable if the Surgery or Tendon/Ligament/Rotator Cuff benefits are payable for the same surgery.

Tendon/Ligament/Rotator Cuff *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives a torn, ruptured or severed tendon, ligament, or rotator cuff as the result of injuries sustained in a *covered accident.* The *injury* must be treated within 60 days of the *covered accident* and repaired through surgery within 365 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Transportation *We* pay the amount shown in the Schedule of Insurance if a *covered person* must travel more than 50 miles one way to receive special treatment at a *hospital* or free standing treatment facility due to a *covered accident.* The treatment must be prescribed by a *doctor* and not available locally. This benefit is payable up to three times per *covered person* per *covered accident* and is not payable if transportation is provided by *ambulance* or *air ambulance.*

X - Ray *We* pay the amount shown in the Schedule of Insurance if a *covered person* receives an x-ray as the result of injuries sustained in a *covered accident.* The test must be prescribed by a *doctor* and performed in a *doctor's* office or a *hospital* on an *inpatient* or *outpatient* basis and performed within 90 days of the *covered accident.* This benefit is payable once per *covered person* per *covered accident.*

Payment of Benefits For covered loss of life, *we* pay the beneficiary described below.

For all other covered losses, *we* pay the *covered person,* if he or she is living. If not, *we* pay the beneficiary described below.

We pay all benefits in a lump sum, as soon as *we* receive proof of loss which is acceptable to *us.* This should be sent to *us* as soon as possible.

The Beneficiary

You decide who gets this benefit if *you* die. *You* should have named a beneficiary on *your* enrollment form. *Your* beneficiary designation should be maintained by *your employer. You* can change *your* beneficiary at any time by giving *us* written notice, unless *you* have assigned this insurance. But the change will not take effect until the *employer* gives *you* written confirmation of the change.

If the *employee* named more than one person, but didn't tell *us* what their shares should be, they will share equally. If someone the employee named dies before the employee, that person's share will be divided equally by the beneficiaries still alive, unless the employee has specified otherwise.

If there is no beneficiary when the employee dies, we will pay this benefit to one of the following: (a) his or her estate; (b) his or her spouse; (c) his or her parents; (d) his or her children; or (e) his or her brothers and sisters.

CGP-3-AC-BEN-12 B476.0011

All Options

Exclusions

This *plan* will not pay benefits for any injury caused by or related to, directly or indirectly:

- Sickness, disease, mental infirmity or medical or surgical treatment.
- Voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for a *covered person* by a *doctor,* and (2) it was used as prescribed. In the case of a non-prescription drug, this *plan* does not pay for any *accident* resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
- Declared or undeclared war, act of war, or armed aggression.
- Service in the armed forces, National Guard, or military reserves of any state or country.
- Taking part in a riot or civil disorder.
- Commission of, or attempt to commit a felony or to which a contributing cause was the *covered person's* being engaged in an illegal occupation.
- Treatment rendered or *hospital confinement* outside the United States or Canada.
- Intentionally self inflicted injury, while sane or insane.
- Suicide or attempted suicide, while sane or insane.

- Travel or flight in any kind of aircraft, including any aircraft owned by or for the *employer* except as a fare-paying passenger on a common carrier.
- Participation in any kind of sporting activity for compensation or profit, including coaching or officiating.
- Riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Participation in hang gliding, bungee jumping, sailgliding, parasailing, parakiting ballooning, parachuting, or skydiving.
- Job related or on the job injuries.
- An accident that occurred before the *covered person* is covered by this *plan.*
- Injuries to a dependent child received during the birth.

CGP-3-AC-EXC-12-MI B476.0017

PORTABILITY PRIVILEGE

Note This section does not apply to residents of Kansas, Maine, or South Dakota.

Definition As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides *accident* coverage.

Portability Conditions Portability is subject to all of the conditions described below.

- *You* may port *your* coverage or coverage for any of *your* dependents if coverage under this *plan* ends because *you:* (1) have terminated employment; (2) stop being a member of an eligible class of *employees;* or (3) this *plan* ends.
- *You* may not Port *your* coverage or coverage for any of *your* dependents if: (1) coverage under this *plan* ends due to *your* failure to pay any required Premium; or (2) *you* have reached age 70 on or before *your* coverage under this *plan* ends.

Portability Options *You* may port: (1) *your* coverage only; (2) *your* coverage and the coverage of *your* covered spouse; (3) *your* coverage and the coverage of all of *your* covered dependents; or (4) if *you* are a single parent, *your* coverage and the coverage of all of *your* covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date *your* coverage under this *plan* ends in order to be eligible to port.

If *you* die while covered for dependent *accident* coverage, *your* spouse may port the dependent *accident* coverage as described above. *Your* spouse and dependent children must be covered under this *plan* on the date of your death. But this option is not available if (1) there is no surviving spouse; or (2) the surviving spouse has reached age 70 on the date *you* die.

The Portable Certificate of Coverage The portable certificate of coverage provides group *accident* coverage. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this *plan.*

The premium for the portable certificate of coverage will be based on: (1) *your* rate class under this *plan;* and (2) *your* or *your* surviving spouse's age bracket as shown in the Accident Portability Coverage Premium Notice.

How to Port *You* or *your* surviving spouse must: (1) apply to *us* in writing; and (2) pay the required premium. *You* or *your* surviving spouse must do this within 31 days from the date *your* coverage under this *plan* ends.

We will not ask for *proof* that *you* or *your* surviving spouse are in good health.

DEFINITIONS

Accident This term means an event or occurrence that was not reasonably foreseeable, or that could not have been reasonably expected or anticipated. The term *accident* does not include a *sickness.*

Accidental Death This term means death caused by an *accident* independent of *sickness,* bodily infirmity, or any other cause and which is not excluded under the Limitations and Exclusions section.

Alternate Care Facility This term means a facility that is licensed according to state and/or local laws to provide skilled care, intermediate care, intermingled care, custodial care, or rehabilitative care as an alternative to care at a *hospital.*

Child Care Center This term means a program of child care which: (1) is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and (2) charges a fee for the care of children. The term does not include child care provided by a: (a) parent; (b) stepparent; (c) grandparent; (d) sibling; (e) aunt; or (f) uncle.

Covered Accident This term means an *accident* that:

- Occurs while *your* coverage or *your* dependent's coverage under this policy is in effect.
- Results in a bodily *injury* and
- Is not otherwise excluded under the terms of this policy.

Common Carrier This term means any land, air or water conveyance operated under a license to transport passengers for hire.

Covered Person This term means an *employee* or dependent insured by this *plan.*

Coma This term means a state of complete mental unresponsiveness, due to *injury,* with no evidence of appropriate responses to stimulation, as diagnosed by a *doctor.*

Companion This term means a spouse, domestic partner, civil union partner, sibling, child, parent, grandparent, or any primary care giver.

Dentist This term means a licensed *doctor* of dentistry, operating within the scope of his or her license, in the state in which he or she is licensed.

Dislocation This term means a completely separated joint due to an *injury.* A partial *dislocation* means the joint is misaligned but not completely dislocated, as diagnosed by a *doctor.*

Doctor This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

Emergency Room This term means a department of the *hospital* that is designated for emergency care of accidental injuries. This area must be staffed and equipped to handle trauma, be supervised and provide treatment by *doctors,* and provide care seven days per week, 24 hours per day.

Epidural Anesthesia This term means a form of regional anesthesia involving injection of drugs through a catheter placed into the epidural space. The epidural must be administered due to a *covered accident,* and does not include treatment for childbirth or diseases.

Fracture This term means a broken bone that can be determined by a diagnostic exam. A chip *fracture* is a *fracture* in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached.

Hospital This term means a short-term, acute care general facility, which:

(1) is primarily engaged in providing, by or under the continuous supervision of *doctors,* to *inpatients,* diagnostic services and therapeutic services for diagnosis, treatment and care of sick or injured persons;

(2) has organized departments of medicine and major surgery;

(3) has a requirement that every patient must be under the care of a *doctor* or *dentist;*

(4) provides 24 hour nursing service by or under the supervision of a registered professional nurse(R.N.);

(5) is duly licensed by the agency responsible for licensing such *hospitals;* and

(6) is not, other than incidentally: (a) a place of rest; (b) a place primarily for the treatment of tuberculosis; (c) a place for the aged; (d) a place for drug addicts or alcoholics; or (e) a place for convalescent, custodial, educational or rehabilitative care.

Hospital Intensive Care Unit This term means a designated area of a *hospital* that

(1) provides the highest quality of medical care and is restricted to patients who are critically ill or injured and who require intensive comprehensive observation and care;

(2) is separate and apart from the surgical recovery room and from rooms, beds, wards, and units customarily used for patient confinement

(3) is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;

(4) is under continuous observation by a specially trained nursing staff assigned exclusively to the intensive care unit on a 24 hour basis and is assigned a *doctor* on a full-time basis.

Hospital Confinement This term means admission to a *hospital* as an *inpatient* for at least 24 consecutive hours by a *doctor* for an *injury.*

Injury This term means unintentional physical damage or harm caused directly by an *accident* and not due to *sickness,* disease or any other causes. The *injury* must occur while you or your covered dependent are insured under this *plan.*

Inpatient This term means a patient who is admitted to a *hospital* for an *injury.*

Occupational Therapy This term means the treatment of a physically disabled person by means of constructive activities designed and adapted to promote the restoration of the *covered person's* ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the *covered person's* particular occupational role. Occupational therapy does not include diversional, recreational, vocational therapies(i.e. hobbies, arts and crafts).

Occupational Therapist This term means a person, other than you or a family member, who: 1) possesses the designation "Occupational Therapists Registerd(OTR)", 2) is licensed by the state to practice *occupational therapy,* 3) performs services which are allowed by his licenses; and 4) performs services for which benefits are provided by this *plan.*

Organized Sport This term means a sport activity that is governed by an organization and requires formal registration to participate. Proof of registration will be required at claim time.

Outpatient Treatment This term means medical services that a *covered person* receives when not confined as an *inpatient* in a *hospital.*

Physical Therapy This term means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following *injury* or loss of a body part.

Physical Therapist This term means a person, other than you or a family member, who: 1) is licensed by the state to practice *physical therapy;* 2) performs services which are allowed by his or her license; 3) performs services for which benefits are provided by this Policy and 4) practices according to the code of ethics of the American Physical Therapy Association.

Rehabilitative Unit This term means an appropriately licensed facility or separate section of a *hospital* that provides rehabilitation care services on an *inpatient* basis and is designated, staffed and equipped to provide restorative services under the supervision of a trained and experienced rehabilitation *doctor.* A rehabilitation unit is not: a nursing home; an extended care facility; a skilled nursing facility; a rest home or home for the aged; a hospice care facility; a place for alcoholics or drug addicts; or an assisted living facility.

Sickness This term means a disease, illness or other condition not related to *injury* including diseases or infections except when the due to an accidental cut or wound.

Urgent Care Facility This term means a health care facility that is organizationally separate from a *hospital* and whose primary purpose is the offering and provision of immediate, short term medical care, without appointment, for urgent care.

We, Us and Our These terms mean The Guardian Life Insurance Company of America.

You or Your These terms mean the insured *employee.*

CGP-3-AC-DEF-12 B476.0026

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

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

All Options

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

CGP-3-GLOSS-90 B750.0015

All Options

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

CGP-3-GLOSS-90 B750.0006

All Options

Employer means KALAMAZOO VALLEY COMMUNITY COLLEGE .

CGP-3-GLOSS-90 B900.0051

All Options

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

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90 B750.0229

All Options

Initial Dependents means those *eligible dependents* you have at the time you first become eligible for *employee* coverage. If at this time you do not have any *eligible dependents,* but you later acquire them, the first *eligible dependents* you acquire are your *initial dependents.*

CGP-3-GLOSS-90 B900.0006

All Options

Newly Acquired Dependent means an *eligible dependent* you acquire after you already have coverage in force for *initial dependents.*

CGP-3-GLOSS-90 B900.0008

All Options

Plan means the *Guardian* group *plan* purchased by your *employer,* except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

CGP-3-GLOSS-90 B900.0039

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
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