YOUR GROUP INSURANCE PLAN BENEFITS

CHRISTIAN RESEARCH INSTITUTE
CLASS 0001
DENTAL

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

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.

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

CGP-3-R-STK-90-3 B110.0023

TABLE OF CONTENTS

Value-Added Programs - This Is Not Insurance

Guardian has arranged to make available selected value-added programs for eligible Guardian policyholders and/or *covered persons* who may be entitled to receive certain services and supplies from various companies.

The value-added programs are not insurance. The services and supplies provided under these programs are not covered by this plan. Guardian assumes no liability for the services and supplies provided under these programs, or for the amounts charged by the companies providing such service and supplies.

Policyholders and *covered persons* will be provided with complete details regarding each program, including: (a) what is discounted; (b) the amount of the discounts; (c) how the discounts can be accessed; (d) any associated fees or charges; (e) any eligibility requirements; and (f) a telephone number to call with questions about the program.

The policyholder and *covered persons* may be eligible for the following program(s):

- Enrollment Vendor Access Program.
- FMLA Administrative Services.
- Comprehensive Employee Assistance Program (EAP) Services.
- FlexPlan Premium Only Plan (FlexPlan).

CGP-3-VAP-11 B119.0011

- COBRA Administration Services.
- Dental Referral Services.
- Discounts on Dental Care Services and Supplies Not Covered By Your Plan.
- Vision Access.

CGP-3-VAP-11 B119.0014

- Office Max.
- Kelly Temporary Services.
- Dell Computers.
- Epic Hearing Care.
- 1-800-Flowers.

When this plan ends, access to the value-added programs ends for the policyholder and for all persons covered under the plan. When a policyholder no longer meets the conditions for eligibility for a value-added program, access to that program ends for the policyholder and for all persons covered under the plan.

When a *covered person's* coverage under this plan ends, access to the value-added programs ends for that person. When a covered person no longer meets the conditions for eligibility for a value-added program, access to that program ends for the covered person.

Guardian reserves the right to terminate, modify or replace any program at any time.

CGP-3-VAP-11 B119.0017

IMPORTANT CANCELLATION INFORMATION

Please Read The Provisions Entitled "When Coverage Ends" and "When Dependent Coverage Ends" Found On Pages CGP-3-EC-90-3.0, CGP-3-DEP-90-9.0.

CGP-3-NCCANC-96 B120.0033

IMPORTANT NOTICE

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE.

CGP-3-MSDIS-NC-00 B120.0052

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

CGP-3-R-GENPRO-90 B160.0012

Limitation of Authority

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

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

Incontestability

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

No statement in any application, except a fraudulent statement in an application for long term disability or major medical coverages, if provided by this *plan,* 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-NC-90 B160.0029

Dental Claims Provisions

Your right to make a claim for any dental 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 180 days of the loss.

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

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

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

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

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

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

CGP-3-R-AHC-90 B160.0100

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87 B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

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

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

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

Conversion

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

CGP-3-R-COBRA-96-1 B235.0164

If You Die While Insured

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

CGP-3-R-COBRA-96-2 B235.0075

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

CGP-3-R-COBRA-96-3 B235.0178

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

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

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

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

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

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

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

CGP-3-R-COBRA-96-4 B235.0198

Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4 B235.0195

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Employee Coverage

Eligible Employees

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

Other Conditions

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

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

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

CGP-3-EC-90-1.0 B489.0122

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

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

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

CGP-3-EC-90-2.0 B489.0070

When Your Coverage Ends

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0 B489.0075

Dependent Coverage

B200.0271

Eligible Dependents For Dependent Dental Benefits

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

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

CGP-3-DEP-90-2.0 B489.0301

Adopted Children, Step-Children And Foster Children

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

Dependents Not Eligible

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

CGP-3-DEP-90-3.1 B264.0009

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, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B449.0045

Waiver Of Dental Late Entrants Penalty

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

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

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

CGP-3-DEP-90-5.0 B200.0749

When Dependent Coverage Starts

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

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

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

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

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

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

CGP-3-DEP-90-6.0 B489.0055

Exception

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

CGP-3-DEP-90-7.0 B200.0692

Newborn, Adopted And Foster Children

We cover your newborn child for dependent benefits from the moment of birth. We cover your adopted child for dependent benefits from the date of adoption or the date of placement by a licensed child placement agency, whichever comes first. We cover your foster child for dependent benefits from the date the child is placed in the foster home.

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

CGP-3-DEP-90-8.0 B489.0020

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 12:01 a.m. on the date the child attains this coverage's age limit, when he or she marries, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0 B489.0048

DENTAL HIGHLIGHTS

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

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

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

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

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

CGP-3-DENT-HL-90 B497.0070

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

  For Group I Services 100%
  For Group II Services 90%
  For Group III Services 60%
  For Group IV Services 50%

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

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

B497.0089

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

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

- **Lifetime Payment Limit for Orthodontic Treatment**

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

CGP-3-DENT-HL-90 B497.0105

DENTAL EXPENSE INSURANCE

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

CGP-3-DNTL-90-1 B490.0036

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that belong to DentalGuard Preferred, a dental preferred provider organization (PPO).

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

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

When you enroll in this *plan,* you and your dependents get a dental *plan* ID card and information about current dental preferred providers. A *covered person* must present his ID card when he goes to a preferred provider. Most preferred providers prepare necessary claim forms for the *covered person,* and submit the forms to us. We send the *covered person* an explanation of this *plan's* benefit payments.

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

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

CGP-3-DNT-PPO-A-NC B497.0894

Covered Charges

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

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

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

CGP-3-DG3-CC-93 B497.0052

Alternate Treatment

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

Proof of Claim

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

CGP-3-DG3-ALT-92 B497.0005

Pre-Treatment Review

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

Pre-Treatment Review (Cont.)

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

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

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

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

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

CGP-3-DG3-PTR-92 B497.0006

Benefits From Other Sources

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

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

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

CGP-3-DNTL-90-5 B497.0968

The Benefit Provision - Qualifying For Benefits

Group I, II And III Non-Orthodontic Services

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

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

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

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

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

CGP-3-DNTL-92-7 B497.0101

Group IV Orthodontic Services

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

We pay for Group IV *covered charges* at the applicable payment rate. There are different payment rates which apply to *covered charges* for services from a PPO Provider and a Non-PPO Provider. Using the treatment plan, we calculate the total benefit we will pay. We divide this into equal payments, which we spread out over the shorter of two years or the proposed length of treatment.

We make the initial payment when the active *appliance* is first placed. We make further payments at the end of each subsequent three month period. But treatment must continue and the *covered person* must stay insured. We limit what we pay during a *covered person's* lifetime to $1,000.00. What we pay is based on all of the terms of this *plan.*

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

CGP-3-DNTL-92-8 B497.0049

Non-Orthodontic Family Deductible Limit

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

CGP-3-DNTL-90-9 B497.0265

Cleft Lip And Palate

To the extent otherwise covered by this *plan,* we pay benefits for covered charges for tooth capping, prosthodontic, and orthodontic services necessary for the care and treatment of cleft lip and palate in a covered dependent child. What we pay is based on all of the terms of this *plan.*

"Cleft lip and palate" as used in this section means a congenital cleft in the lip or palate, or both.

CGP-3-R-DCLP-SC-94 B497.0895

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

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

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

Benefits for Group II Services performed by a preferred provider are paid at a rate of 90%

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

Benefits for Group III Services performed by a preferred provider are paid at a rate of 60%

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

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

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

CGP-3-DRATE-90 B497.0038

After This Insurance Ends

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

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

CGP-3-DNTL-90-10 B490.0045

Special Limitations

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

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

A late entrant is a person who: (1) becomes insured more than 31 days after he is eligible; or (2) becomes insured again, after his coverage lapsed because he did not make required payments. However, a child enrolled more than 31 days after he is eligible, due to an administrative or court order for a parent to provide health coverage will not be considered a late entrant.

CGP-3-DTL-PN-95-NC B497.0897

Teeth Lost or Missing Before A Covered Person Becomes Insured By This Plan

A *covered person* may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this *plan.* We won't pay for a *prosthetic device* which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the *covered person* became insured by this *plan.*

If This Plan Replaces Another Plan

This *plan* may be replacing another plan your *employer* had with some other insurer.

We don't want anyone to lose benefits when this happens. So we pay for certain charges incurred before this *plan* starts, if: (1) the *covered person* was insured by the old *plan;* and (2) the old *plan* would have paid for such charges. But this *plan* must start not more than 60 days after the old *plan* ends. And the covered person must be insured by this *plan* from the start.

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

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

CGP-3-DG3-SL-93 B497.0911

Exclusions

- We won't pay for:
  - Oral hygiene, plaque control or diet instruction.
  - Precision attachments.
  - Desensitizing medicaments.
  - Prescription medication.
- We won't pay for:
  - Treatment which does not meet accepted standards of dental practice.
  - Treatment which is experimental in nature.
- We won't pay for any *appliance* or *prosthetic device* used to:
  - Change vertical dimension.
  - Restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment.*
  - Splint or stabilize teeth for periodontic reasons.
  - Replace tooth structure lost as a result of abrasion or attrition.

- We won't pay for any service furnished for cosmetic reasons. This includes, but is not limited to:
  - Characterizing and personalizing *prosthetic devices.*
  - Making facings on *prosthetic devices* for any teeth in back of the second bicuspid.

  But we will pay benefits for services for cosmetic purposes to correct congenital defects or anomalies of a covered dependent child.
- We won't pay for replacing an *appliance* or *prosthetic device* or processed veneer with a like appliance or device, unless:
  - It is at least ten years old and can't be made usable.
  - It is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- We won't pay for any service, appliance, device or modality intended to treat disturbances of the temporo-mandibular joint.
- We won't pay for:
  - Replacing a lost, stolen or missing *appliance* or *prosthetic device.*
  - Making a spare *appliance* or device.
- We won't pay for:
  - Implants.
  - Tooth transplants.
  - Surgical repositioning of the jaw.
- We won't pay for treatment needed due to a condition for which benefits are payable by Worker's Compensation or similar laws.
- We won't pay for treatment for which no charge is made. This usually means treatment furnished by:
  - The *covered person's employer,* labor union or similar group, in its dental or medical department or clinic.
  - A facility owned or run by any governmental body.
  - Any public program, except Medicaid, paid for or sponsored by any government body.

  But if a charge is made and we are legally required to pay it, we will.
- We won't pay for overdentures.

List of Covered Dental Services

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

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

CGP-3-DNTL-90-13 B490.0048

Group I - Preventive Dental Services

(Non-Orthodontic)

Prophylaxis And Fluoride Treatments

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

Office Visits And Examinations

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

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

CGP-3-DNTL-90-14 B497.0983

Space Maintainers

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

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

Fixed And Removable Appliances

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

CGP-3-DNTL-90-14 B497.0298

Diagnostic Services

Allowance includes examination and diagnosis.

- X-Rays
  - Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 60 consecutive month period).
  - Bitewing films (limited to a maximum of four films in one visit, in any 12 consecutive month period).
  - Other intraoral periapical or occlusal films - single films (limited to 4 periapical & 2 occlusal in any 12 consecutive month period).
  - Extraoral superior or inferior maxillary film (limited to 2 in any 12 consecutive month period).

- Panoramic film, maxilla and mandible (only for treatment of accidents, cysts & tumors).

CGP-3-DNTL-90-14 B497.0761

Dental Sealants Posterior Teeth

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

CGP-3-DNTL-90-14 B497.0981

Group II - Basic Dental Services
(Non-Orthodontic)

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

Diagnostic Services Allowance includes examinations and diagnosis.

- Diagnostic casts - complex restorative cases only.
- Biopsy and examination of oral tissue.

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

- Amalgam restorations.
- Synthetic restorations: Silicate cement, Acrylic or plastic, and Composite resin.
- Crowns: Stainless steel.
- Pins: Pin retention, exclusive of restorative material.

CGP-3-DNTL-90-15.0 B497.0306

Endodontic Services Allowance includes routine X-Rays and cultures, but excludes final restoration.

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

CGP-3-DNTL-90-15.0 B497.0308

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

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

- Gingivectomy, per tooth (fewer than 6 teeth).
- Sub-gingival curettage and root planing, per quadrant (limited to a maximum of 4 quadrants in any 12 consecutive month period).
- Pedicle or free soft tissue grafts, including donor sites.
- Osseous surgery, including flap entry and closure, per quadrant (once every 3 years).
- Osseous grafts, including flap entry, closure and donor sites.
- Muco-gingival surgery.
- Occlusal adjustment, not involving restorations and done in conjunction with periodontic surgery, per quadrant (limited to a maximum of 4 quadrants in any 36 consecutive month period).

CGP-3-DNTL-90-15.0 B497.0311

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

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

Other Surgical Procedures

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

CGP-3-DNTL-90-15.1 B497.0313

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

- Adding teeth to partial dentures to replace extracted natural teeth.

- Repairs to crowns - allowance based on the extent and nature of damage and the type of material involved.

Other Services

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

CGP-3-DNTL-90-15.1 B497.0315

Restorative Services

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

- Inlays
- Onlays, in addition to inlay allowance.

- Crowns and Posts
  - Acrylic with metal.
  - Porcelain.
  - Porcelain with metal.
  - Full cast metal (other than stainless steel).
  - 3/4 cast metal (other than stainless steel).
  - Cast post and core, in addition to crown (not a thimble coping).
  - Steel post and composite or amalgam core, in addition to crown.
  - Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown.
  - Acrylic or plastic, without metal
  - Crown buildup.
  - Labial veneers.

- Recementation
  - Inlay or onlay.
  - Crown.
  - Bridge.

Prosthodontic Service

Specialized technique and characterizations are not covered.

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

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

- Bridge Pontics
  - Cast metal, sanitary.
  - Plastic or porcelain with metal.
  - Slotted facing.
  - Slotted pontic.

- Simple stress breakers, per unit.

- Removable bridges, unilateral partial, one piece chrome casting, clasp attachment, including pontics.

- Dentures - Allowance includes all adjustments done by the dentist furnishing the denture in the first 6 months after installation.

  - Full dentures, upper or lower.
  - Partial dentures - Allowance includes base, all clasps, rests and teeth.
  - Upper, with two chrome clasps with rests, acrylic base.
  - Upper, with chrome palatal bar and clasps, acrylic base.
  - Lower, with two chrome clasps with rests, acrylic base.
  - Lower, with chrome lingual bar and clasps, acrylic base.
  - Stayplate base, upper or lower (anterior teeth only).

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

- Denture repairs, metal - Allowance based on the extent and nature of damage and on the type of materials involved.

- Denture duplication, jump case (limited to once per denture in any 60 consecutive month period).

- Denture reline (limited to once per denture in any 24 consecutive month period):

  - Office reline.
  - Laboratory reline.

- Denture adjustments (limited to adjustments made by a dentist other than the one providing the denture, and adjustments are more than 6 months after the initial installation).

- Tissue conditioning (limited to a maximum of 2 treatments per arch in any 24 consecutive month period).

- Repairs to bridges - allowance based on the extent and nature of damage and the type of materials involved).

CGP-3-DNTL-90-16 B497.0317

CGP-3-DNTL-90-16 B497.0322

Orthodontic Services

- Any Group I, II or III service in connection with *orthodontic treatment.*

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

- Active *appliances* - All types - Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active *appliance,* and all related office visits including post-treatment stabilization.

CGP-3-DNTL-90-17 B490.0052

CERTIFICATE AMENDMENT

The certificate is amended as follows:

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

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-A-1 B531.0099

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

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

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

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

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

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

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.

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) true group coverage, whether insured or uninsured, including prepayment, group practice, or individual practice coverage; and (2) governmental benefits, as permitted by law.

This term does not include: (a) school accident type coverage; (b) blanket coverage; (c) franchise individual coverage; (d) automobile and homeowner coverage; or (e) Medicaid, and coverage under other governmental plans when, by law, its benefits are excess to those of any private insurance program or other non-governmental program.

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

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

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

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

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

Order Of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

Effect On The Benefits Of This Plan

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

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

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.

CGP-3-R-COB-05 B555.0248

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS.1 B750.0100

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

CGP-3-GLOSS.1 B750.0295

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

CGP-3-GLOSS.1 B750.0205

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

CGP-3-GLOSS.1 B750.0296

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

CGP-3-GLOSS.1 B750.0207

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

CGP-3-GLOSS.1 B750.0208

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

CGP-3-GLOSS.1 B750.0210

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.1 B750.0064

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

CGP-3-GLOSS.1 B750.0065

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.1 B750.0101

Employer means CHRISTIAN RESEARCH INSTITUTE .

CGP-3-GLOSS.1 B750.0070

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.1 B750.0074

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 35 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

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.1-2 B750.0114

Injury with respect to this *plan's* dental expense insurance, means all damage to a *covered person's* mouth due to an accident, and all complications rising from that damage. But the term *injury* does not include damage to teeth, *appliances* or *prosthetic devices* which results from chewing or biting food or other substances.

CGP-3-GLOSS.1-2 B750.0216

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

CGP-3-GLOSS.1-2 B750.0122

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* It includes: (a) diagnostic services; (b) the treatment plan; (c) the fitting, making and placement of an *active appliance;* and (d) all related office visits, including post-treatment stabilization.

CGP-3-GLOSS.1-2 B750.0218

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.1-2 B750.0132

Prosthetic Device means a restorative service which is used to replace missing or lost teeth or tooth structure. It includes all types of dentures, crowns, bridges, veneers, pontics and cast restorations.

CGP-3-GLOSS.1-2 B750.0298

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

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

- **Name of Plan:**

  CHRISTIAN RESEARCH INSTITUTE GROUP INSURANCE PLAN

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

  CHRISTIAN RESEARCH INSTITUTE

  Address: 6295 BLAKENEY PARK DRIVE

  CHARLOTTE NC 28277

  Phone Number: (00011)-(00012)-8282

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

- **Plan Number:** 501

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

  CHRISTIAN RESEARCH INSTITUTE

  Address: 6295 BLAKENEY PARK DRIVE

  CHARLOTTE NC 28277

  Phone Number: (00011)-(00012)-8282

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

  CHRISTIAN RESEARCH INSTITUTE

  Address: 6295 BLAKENEY PARK DRIVE

  CHARLOTTE NC 28277

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

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

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

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

Class 0001 ALL ELIGIBLE EMPLOYEES

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

B800.0047

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com

GUARDIAN℠

The Guardian Life Insurance Company of America
7 Hanover Square
New York, New York 10004-2616

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