This is Your

PARTICIPATING PROVIDER ORGANIZATION INSURANCE POLICY

Issued by

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

This is Your individual Policy for participating provider organization insurance coverage issued by The Guardian Life Insurance Company of America. This Policy, together with the attached Schedule of Benefits, applications, and any amendment or rider amending the terms of this Policy, constitute the entire agreement between You and Us.

You have the right to return this Policy. Examine it carefully. If You are not satisfied, You may return this Policy to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Policy. We will refund any Premium paid including any Policy fees or other charges.

Renewability. The renewal date for this Policy is January 1 of each year. This Policy will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Policy or by the Subscriber upon 30 days prior written notice to Us.

This Policy offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our DentalGuard Preferred Network who are located within Our Service Area. You should always consider receiving dental care services first through the in-network benefits portion of this Policy.
2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Policy provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. See the Schedule of Benefits section of this Policy for more information.

READ THIS ENTIRE POLICY CAREFULLY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS POLICY.

This Policy is governed by the laws of New York State.

The insurance evidenced by this Policy provides DENTAL insurance ONLY.

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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SECTION I

Definitions

Defined terms will appear capitalized throughout the Policy.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Policy for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Appeal: A request for Us to review a Utilization Review decision again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Policy.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Policy.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children.

Emergency Dental Care: Emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Refer to the Pediatric Dental Care and Adult Dental Care sections of this Policy for details.

Exclusions: Dental care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover. The In-Network Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

Medically Necessary: See the How Your Coverage Works section of this Policy for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

New York State of Health ("NYSOH"): The New York State of Health, the Official Health Plan Marketplace. The NYSOH is a marketplace where individuals, families and small businesses can learn about their health insurance options; compare plans based on cost, benefits and other important features; apply for and receive financial help with premiums and cost-sharing based on income; choose a plan; and enroll in coverage. The NYSOH also helps eligible consumers enroll in other programs, including Medicaid, Child Health Plus and the Essential Plan.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Coinsurance or Copayments are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service that You owe before We begin to pay for a particular Covered Service.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of dental care services We do not Cover. The Out-of-Pocket Limit only applies to benefits that are part of the pediatric dental essential health benefit.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at dentalexchange.guardiandirect.com or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: A calendar year ending on December 31 of each year.

Policy: This Policy issued by The Guardian Life Insurance Company of America, including the Schedule of Benefits and any attached riders.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, or device that the Covered Service, procedure, treatment plan, or device is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Policy.

Premium: The amount that must be paid for Your dental insurance coverage.

Premium Tax Credit: Financial help that lowers Your taxes to help You and Your family pay for private dental insurance. You can get this help if You get health insurance through the NYSOH and Your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly Premium.

Primary Care Dentist ("PCD"): A participating dentist who directly provides or coordinates a range of dental services for You.

Provider: An appropriately licensed, registered or certified dentist, dental hygienist, or dental assistant under Title 8 of the New York State Education Law (or other comparable state law, if applicable) that the New York State Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Provider's services must be rendered within the lawful scope of practice for that type of Provider in order to be Covered under the Policy.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCD to a Specialist) in order to arrange for additional care for a Member.

Schedule of Benefits: The section of this Policy that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: Albany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Clinton, Columbia, Dutchess, Erie, Fulton, Genesee, Greene, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Putnam, Queens, Rensselaer, Richmond, Rockland, Saratoga, Schenectady, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming.

Specialist: A dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia and pediatric dentistry, or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Subscriber: The person to whom this Policy is issued.

UCR (**Usual, Customary and Reasonable):** The cost of a dental service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Us, We, Our: The Guardian Life Insurance Company of America and anyone to whom We legally delegate performance, on Our behalf, under this Policy.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage under this Policy.

You have purchased a dental insurance Policy from Us. We will provide the benefits described in this Policy to You and/or Your covered Dependents. You should keep this Policy with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Policy only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Policy; and
- Received while Your Policy is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit our website at dentalexchange.guardiandirect.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

D. The Role of Primary Care Dentists.

This Policy does not have a gatekeeper, usually known as a Primary Care Dentist ("PCD"). You do not need a Referral from a PCD before receiving Specialist care.

E. Access to Providers and Changing Providers.

Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients. To see a Provider, call his or her office and tell the Provider that You are a DentalGuard Preferred Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve an authorization to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

F. Out-of-Network Services.
We Cover the services of Non-Participating Providers. However, some services are only Covered when you go to a Participating Provider. See the Schedule of Benefits section of this Policy for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject To Preauthorization.
Our Preauthorization is not required before You receive certain Covered Services.

H. Medical Management.
The benefits available to You under this Policy may be subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

I. Medical Necessity.
We Cover benefits described in this Policy as long as the dental service, procedure, treatment, test, device, or supply (collectively, "service") is Medically Necessary (e.g. Crowns, inlays, onlays, buildups, post & cores, scaling and root planing and osseous surgery). The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your dental records;
- Our dental policies and clinical guidelines;
- Dental opinions of a professional society, peer review committee or other groups of Physicians;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of health care professionals in the generally-recognized health specialty involved.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of dental practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting.

See the Utilization Review and External Appeal sections of this Policy for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

J. Important Telephone Numbers and Addresses.

- CLAIMS
  P.O Box 981587, El Paso, TX 79998-1587
  (Submit claim forms to this address.)

  916-388-3604
  (Submit claim forms to this fax number.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  844-561-5600

- MEMBER SERVICES
  844-561-5600
  (Member Services Representatives are available Monday – Friday 9:00 a.m. – 9:00 p.m. Eastern Time)

- OUR WEBSITE
  dentalexchange.guardiandirect.com

SECTION III

Cost-Sharing Expenses and Allowed Amount

A. Deductible.
Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Policy for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Policy. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Policy collectively total the family Deductible amount in the Schedule of Benefits section of this Policy in a Plan Year, no further Deductible will be required for any person covered under this Policy for that Plan Year.

There are different Deductibles for services provided by Participating Providers and Non-Participating Providers. The Deductibles for Participating Providers apply to Covered in-network services. The Deductible for Non-Participating Providers apply to Covered out-of-network Services.

You have a separate In-Network and Out-of-Network Deductible. Cost-Sharing for out-of-network services does not apply towards Your In-Network Deductible. Cost-Sharing for in-network services does not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.**

The Deductible runs from January 1 to December 31 of each calendar year.

B. Copayments.
There are no Copayments for Covered Services under this Policy.

C. Coinsurance.
Except where stated otherwise, after You have satisfied the Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Policy. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit.
When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Policy for the pediatric dental essential health benefit, We will provide coverage for 100% of the Allowed Amount for Covered in-network Services for the remainder of that Plan Year for the pediatric dental essential health benefit. If You have other than individual coverage, the individual In-Network Out-of-Pocket Limit applies to each Member under age 19 covered under this Policy. Once a Member under age 19

meets the In-Network Out-of-Pocket Limit for one (1) Member under age 19, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person for the pediatric dental essential health benefit. If this Policy covers more than one Member under age 19, when two (2) or more Members under age 19 covered under this Policy have collectively met the In-Network Out-of-Pocket Limit for two (2) or more Members under age 19 in payment of In-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Policy, We will provide coverage for 100% of the Allowed Amount for the pediatric dental essential health benefit for the rest of that Plan Year.

Cost-Sharing for out-of-network services, except for out-of-network services approved by Us as an in-network exception, does not apply toward Your In-Network Out-of-Pocket Limit. The In-Network Out-of-Pocket Limit runs from January 1 to December 31 of each calendar year.

E. Out-of-Network Out-of-Pocket Limit for the Pediatric Dental Essential Health Benefit.
This Policy does not have an Out-of-Network Out-of-Pocket Limit on the pediatric dental essential health benefit.

F. Out-of-Network Out-of-Pocket Limit.
This Policy does not have an Out-of-Network Out-of-Pocket Limit.

G. In-Network Annual Maximum.
This Policy has an in-network annual maximum for in-network non-orthodontic benefits described in the Adult Dental Care section of this Policy. There is no annual maximum for the in-network pediatric dental essential health benefit. When Members receiving adult dental care or additional pediatric dental care have met the in-network annual maximum for non-orthodontic in-network Covered Services in the Schedule of Benefits section of this Policy, no more benefits will be payable for that Member for the remainder of that Plan Year. If you have other than individual coverage, the individual in-network annual maximum for adult dental care benefits applies to each person covered under this Policy. Once a person within a family meets the individual in-network annual maximum for adult dental care, no more benefits for services will be payable for that person. If other than individual coverage applies, when persons in the same family covered under this Policy have collectively met the family in-network annual maximum for benefits described in the Adult Dental Care section of this Policy, no more benefits will be payable for the family for the rest of that Plan Year.

H. Out-of-Network Annual Maximum.
This Policy has an out-of-network annual maximum for out-of-network non-orthodontic benefits. There is no annual maximum for the in-network pediatric dental essential health benefit. Once You have met the out-of-network annual maximum for non-orthodontic out-of-network Covered Services in the Schedule of Benefits section of this Policy, no more benefits will be payable for the remainder of that Plan Year. If you have other than individual coverage, the individual out-of-network annual maximum applies to each person covered under this Policy. Once a person within a family meets the individual out-of-

network annual maximum, no more benefits will be payable for that person. If other than individual coverage applies, when persons in the same family covered under this Policy have collectively met the family out-of-network annual maximum in the Schedule of Benefits section of this Policy, no more benefits will be payable for the family for the remainder of that Plan Year.

I. Your Additional Payments for Out-of-Network Benefits.
When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductible and Coinsurance described in the Schedule of Benefits section of this Policy, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay under Your applicable Copayment, Deductible and Coinsurance may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Participating or Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one inclusive payment in that case, rather than a separate payment for each billed code.

J. Allowed Amount.
"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under this Policy, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider, or the Participating Provider's charge, if less.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. For Providers
For Providers, the Allowed Amount will be the lesser of the Provider's charge and an amount based on Our Participating Provider fee schedule or rate.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card for information on Your financial responsibility when You receive services from a Non-Participating Provider.

SECTION IV

Who Is Covered

A. Who is Covered Under this Policy.

You, the Subscriber to whom this Policy is issued, are covered under this Policy. You must live or reside in Our Service Area to be covered under this Policy. Members of Your family may also be covered depending upon the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.

3. **Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.

4. **Family.** If You selected family coverage, then You, Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Policy.

If You selected parent and child/children or family coverage, Children covered under this Policy include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Grandchildren who are chiefly dependent upon You for support and foster children are covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child qualifies and continues to qualify under this section.

Coverage shall continue for a Child who is a full-time student when the Child takes a medical leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage of the Child is not provided beyond the age at which coverage would otherwise terminate. To qualify for such coverage, We may require that the leave be certified as Medically Necessary by the Child's Physician who is licensed to practice in the state of New York.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Policy at any time.

D. Special Enrollment Periods.
Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days prior to or after the occurrence of one (1) of the following events:

1. You or Your Spouse or Child involuntarily lose minimum essential coverage, including COBRA and state continuation coverage, including if You are enrolled in a non-calendar year group health plan or individual health insurance coverage, even if You have the option to renew the coverage;
2. You, Your Spouse or Child are determined newly eligible for advance payments of the Premium Tax Credit because coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, including as a result of Your employer discontinuing or changing available coverage within the next 60 days, provided that You are allowed to terminate existing coverage;
3. You, Your Spouse or Child lose eligibility for Medicaid coverage, including Medicaid coverage for pregnancy-related services and Medicaid coverage for the medically needy, but not including other Medicaid programs that do not provide coverage for primary or specialty care;
4. You, Your Spouse or Child become eligible for new qualified dental plans because of a permanent move and You, Your Spouse or Child had minimum essential coverage for one (1) or more days during the 60 days before the move; or
5. You, Your Spouse or Child are no longer incarcerated.

Outside of the annual open enrollment period, You, the Subscriber, Your Spouse, or Child, can enroll for coverage within 60 days after the occurrence of one (1) of the following events:

1. You, Your Spouse or Child enrollment or non-enrollment in another qualified dental plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the NYSOH, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, as evaluated and determined by the NYSOH;
2. You, Your Spouse or Child adequately demonstrate to the NYSOH that another qualified dental plan in which You were enrolled substantially violated a material provision of its contract;
3. You gain a Dependent or become a Dependent through birth, adoption or placement for adoption, or placement in foster care or through a child support order or other court order;

4. You gain a Dependent or become a Dependent through marriage and You or Your Spouse had minimum essential coverage for one (1) or more days during the 60 days before the marriage;
5. You lose a Dependent or are no longer considered a Dependent through divorce, legal separation, or upon the death of You or Your Dependents;
6. If You are an Indian, as defined in 25 U.S.C. 450b(d), You and Your Dependents may enroll in a qualified dental plan or change from one (1) qualified dental plan to another one (1) time per month;
7. You demonstrate to the NYSOH that You meet other exceptional circumstances as the NYSOH may provide;
8. You were not previously a citizen, national, or lawfully present individual and You gain such status;
9. You are determined newly eligible or newly ineligible for advance payments of the Premium Tax Credit or cost-sharing reductions; or
10. You are a victim of domestic violence or spousal abandonment, including a Dependent or unmarried victim within a household, are enrolled in minimum essential coverage, and You and Your Dependents seek to enroll in coverage separate from the perpetrator of the abuse or abandonment;
11. You, Your Spouse or Child apply for coverage during the annual open enrollment period or due to a qualifying event, are assessed by the NYSOH as potentially eligible for Medicaid or Child Health Plus, but are determined ineligible for Medicaid or Child Health Plus after open enrollment ended or more than 60 days after the qualifying event;
12. You, Your Spouse or Child adequately demonstrate to the NYSOH that a material error related to plan benefits, service area, or premium influenced Your decision to purchase a qualified dental plan through the NYSOH.

The NYSOH must receive notice and We must receive any Premium payment within 60 days of one (1) of these events.

If You, Your Spouse or Child enroll because You are losing minimum essential coverage within the next 60 days, or You are determined newly eligible for advance payments of the Premium Tax Credit because the coverage You are enrolled in will no longer be employer-sponsored minimum essential coverage, or You gain access to new qualified dental plans because You are moving, and Your selection is made on or before the triggering event, then Your coverage will begin on the first day of the month following Your loss of coverage.

If You, Your Spouse or Child are applying due to a permanent move or marriage, You, Your Spouse or Child can meet the requirement to demonstrate coverage in the 60 days prior to the permanent move or marriage by having minimum essential coverage for one (1) or more days during the 60 days before the move or marriage; living in a foreign country or in a United States territory for one (1) or more days during the 60 days before the move or marriage; or You are an Indian as defined in 25 U.S.C. 450b(d); or You lived for one (1) or more days during the 60 days before the move or marriage in a service area where no qualified health plan was available through the NYSOH.

E. Effective Dates of Coverage for Special Enrollment Periods.
If You, Your Spouse or Child enroll because You got married, Your coverage will begin on the first day of the month following Your selection of coverage. If You, Your Spouse or Child enroll because You gain a Dependent through adoption or placement for adoption, Your coverage will begin on the date of the adoption or placement for adoption. If You, Your Spouse or Child enroll because of a court order, Your coverage will begin on the date the court order is effective.

If You have a newborn or adopted newborn Child and the NYSOH receives notice of such birth within 60 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise coverage begins on the date on which the NYSOH receives notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 60 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. If You have individual or individual and Spouse coverage You must also notify the NYSOH of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 60 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which the NYSOH receives notice, provided that You pay any additional Premium when due.

Advance payments of any Premium Tax Credit are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month.

If You, Your Spouse or Child enroll because of the death of You or Your Dependents, Your coverage will begin on the first day of the month following your selection.

In all other cases, the effective date of Your coverage will depend on when the NYSOH receives Your selection. If Your selection is received between the first and fifteenth day of the month, Your coverage will begin on the first day of the following month, as long as Your applicable Premium payment is received by then. If Your selection is received between the sixteenth day and the last day of the month, Your coverage will begin on the first day of the second month, as long as Your applicable Premium payment is received by then.

F. Domestic Partner Coverage.
This Policy covers domestic partners of Subscribers as Spouses. If You selected family coverage, Children covered under this Policy also includes the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists, or

2. For partners residing where registration does not exist, by:
    a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
        - The partners are both 18 years of age or older and are mentally competent to consent to contract;
        - The partners are not related by blood in a manner that would bar marriage under the laws of the State of New York;
        - The partners have been living together on a continuous basis prior to the date of the application; and
        - Neither individual has been registered as a member of another domestic partnership within the last six (6) months;
    b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
    c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
        - A joint bank account;
        - A joint credit card or charge card;
        - Joint obligation on a loan;
        - Status as an authorized signatory on the partner's bank account, credit card or charge card;
        - Joint ownership of holdings or investments;
        - Joint ownership of residence;
        - Joint ownership of real estate other than residence;
        - Listing of both partners as tenants on the lease of the shared residence;
        - Shared rental payments of residence (need not be shared 50/50);
        - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
        - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
        - Shared household budget for purposes of receiving government benefits;
        - Status of one (1) as representative payee for the other's government benefits;
        - Joint ownership of major items of personal property (e.g., appliances, furniture);
        - Joint ownership of a motor vehicle;
        - Joint responsibility for child care (e.g., school documents, guardianship);
        - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
        - Execution of wills naming each other as executor and/or beneficiary;
        - Designation as beneficiary under the other's life insurance policy;
        - Designation as beneficiary under the other's retirement benefits account;
        - Mutual grant of durable power of attorney;

- Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
- Affidavit by creditor or other individual able to testify to partner's financial interdependence; or
- Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION V
Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Policy for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services for Members through the end of the month in which the Members turn 19 years of age:

A. Emergency Dental Care. We Cover Emergency Dental Care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency Dental Care is not subject to Our Preauthorization.

B. Preventive Dental Care. We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. Routine Dental Care. We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36-month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics. We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics otherwise Covered under this Policy.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures, for Members 15 years of age and above, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of, or leading to orthodontics that are otherwise Covered under this Policy.

H. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION V

Adult Dental Care

A. Waiting Periods For Certain Services

The following services when furnished by a Participating Provider or Non-Participating Provider are not considered covered charges during the waiting period shown in the Schedule of Benefits:

Group II Services

The services shown above are not covered charges under this Policy, and cannot be used to meet this Policy's Deductibles.

B. Supplemental Dental Expense Benefits

We Cover the following dental care services for members 19 years of age and older. Please refer to the Schedule of Benefits for Cost-Sharing requirements.

Group I Services

(Diagnostic & Preventive)

Prophylaxis

Prophylaxis: Limited to a total of one prophylaxis or periodontal maintenance procedures (considered under Periodontal Services) in any six consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus and stains. Also see Periodontal Maintenance under Group III Services.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition: Covered once in any 12 consecutive month period, 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 Member'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.

Office Visits, Evaluations And Examination

Comprehensive oral evaluation – limited to once every 36 consecutive months per Dentist. All office visits, oral evaluations, examinations or limited problem focused re-evaluations: Limited to a total of one in any six consecutive month period. Detailed and extensive oral evaluations are not covered.

Limited oral evaluation – problem focused or emergency oral evaluation: Limited to a total of one in any six consecutive month period. After-hours office visit or emergency palliative treatment.

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 60 consecutive month period.

- Full mouth series, of at least 14 images including bitewings.
- Panoramic image, maxilla and mandible, with or without bitewing radiographs.

Bitewing images: Limited to either a maximum of four bitewing images or a set (seven - eight images) of vertical bitewings, in one visit, once in any 12 consecutive month period.

Intraoral periapical or occlusal images- single images.

Group II Services

(Basic)

Restorative Services

Multiple restorations on one surface will be considered one restoration. Replacement of existing amalgam and resin restorations will only be covered if 36 months has passed since the previous restoration was placed if the member is age 19 or older.

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

Resin restorations: Limited to Anterior Teeth only. Coverage for resins on Posterior Teeth is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents, and local anesthetic.

Prefabricated stainless steel crown, prefabricated resin crown and resin composite crown: Limited to once per tooth in any 24 consecutive month period. Prefabricated stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

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

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. This dental Policy covers a consultation only when no other treatment, other than radiographs, is performed during the visit.

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: (1) dentures; (2) crowns; (3) bridges; (4) inlays or onlays.

Accession of tissue: Accession of exfoliative cytologic smears are considered when performed in conjunction with a biopsy of tooth related origin. Consultation for oral pathology laboratory is considered if done by a Dentist other than the one performing the biopsy.

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.

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

SECTION VII

Exclusions and Limitations

No coverage is available under this Policy for the following:

A. Cosmetic Services.
We do not Cover cosmetic services or surgery unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect, except for pediatric orthodontics as described in the Pediatric and Adult Dental Care sections of this Policy. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeals sections of this Policy unless medical information is submitted.

B. Experimental or Investigational Treatment.
We do not Cover any health care service, procedure, treatment, or device that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments. See the Utilization Review and External Appeal sections of this Policy for a further explanation of Your Appeal rights.

C. Felony Participation.
We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection.

D. Government Facility.
We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law.

E. Medical Services.
We do not Cover medical services or dental services that are medical in nature, including any Hospital charges or prescription drug charges.

F. Medically Necessary.
In general, We will not Cover any dental service, procedure, treatment, test or device that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test or device for which coverage has been denied, to the extent that such service, procedure,

treatment, test or device, is otherwise Covered under the terms of this Policy.

G. Medicare or Other Governmental Program.
We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

H. Military Service.
We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

I. No-Fault Automobile Insurance.
We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

J. Services Not Listed.
We do not Cover services that are not listed in this Policy as being Covered.

K. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

L. Services with No Charge.
We do not Cover services for which no charge is normally made.

M. Workers' Compensation.
We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION VIII

Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Policy. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider; either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at dentalexchange.guardiandirect.com. Completed claim forms should be sent to the address on Your ID card. You may also submit a claim to Us electronically by sending it to the e-mail address on Your ID card.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our Claim determination procedure applies to contractual benefit denials.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Policy.

F. Pre-service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination or Referral), We will

make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. Urgent Pre-service Reviews. With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION IX

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the telephone number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us by calling the telephone number on Your ID card or visit Our website at dentalexchange.guardiandirect.com.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at dentalexchange.guardiandirect.com. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45- day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of one (1) business day of receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) within the earlier of 72 hours or of one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of

the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.
We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Reconsideration.
If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

G. Utilization Review Internal Appeals.
You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a health care professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

H. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request.

Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal.. Written notice of the determination will be provided to You or Your designee and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal.

   If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal appeal or an external appeal.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

I. Full and Fair Review of an Appeal.
We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

J. Appeal Assistance.
If you need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or email cha@cssny.org
Website: www.communityhealthadvocates.org]

SECTION X

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Policy; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal A Determination that A Service Is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your Right to Appeal A Determination that A Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or
2. There does not exist a more beneficial standard service or procedure covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information

from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment, We will provide coverage subject to the other terms and conditions of this Policy. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Policy for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

E. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XI

Termination of Coverage

This Policy may be terminated as follows:

A. Automatic Termination of this Policy.
This Policy shall automatically terminate upon the death of the Subscriber, unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, this Policy will terminate as of the last day of the month for which the Premium has been paid.

B. Automatic Termination of Your Coverage.
Coverage under this Policy shall automatically terminate:

1. For Spouses in cases of divorce, the date of the divorce.
2. For Children, the end of the month in which the Child turns 26 years of age.
3. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.

C. Termination by You.
The Subscriber may terminate this Policy at any time by giving the NYSOH at least 14 days prior written notice.

D. Termination by Us.
We may terminate this Policy with 30 days written notice as follows:

1. For Non-payment of Premiums.
   Premiums are to be paid by the Subscriber to Us on each Premium due date. While each Premium is due by the due date, there is a grace period for each Premium payment. If the Premium payment is not received by the end of the grace period, coverage will terminate as follows:
   - If the Subscriber does not receive advanced payments of the Premium Tax Credit for coverage in the NYSOH and fails to pay the required Premium within a 30-day grace period, this Policy will terminate retroactively back to the last day Premiums were paid. The Subscriber will be responsible for paying any claims submitted during the grace period if this Policy terminates.
   - If the Subscriber receives advanced payments of the Premium Tax Credit and has paid at least one (1) full month's Premium, this Policy will terminate one (1) month after the last day Premiums were paid. That is, retroactive termination will not exceed 61 days. We may pend claims incurred during the 61-day grace period. The Subscriber will be responsible for paying any claims incurred during the 61-day grace period if this Policy coverage terminates.

2. Fraud or Misrepresentation of Material Fact.
   If the Subscriber has performed an act that constitutes fraud or made a misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, this Policy will terminate immediately upon a

written notice to the Subscriber from the NYSOH. However, if the Subscriber makes a misrepresentation of material fact in writing on his or her enrollment application We will rescind coverage if the facts misrepresented would have led Us to refuse to issue this Policy and the application is attached to this Policy. Rescission means that the termination of Your coverage will have a retroactive effect of up to the issuance of this Policy. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

3. If the Subscriber no longer lives, or resides in Our Service Area.

4. The date the Policy is terminated because We stop offering the class of policies to which this Policy belongs, without regard to claims experience or health related status of this Policy. We will provide the Subscriber with at least 30 days prior written notice.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

SECTION XII

Extension of Benefits

Upon termination of insurance, whether due to termination of eligibility, or termination of the Policy, an extension of benefits shall be provided for a period of no less than 30 days for completion of a dental procedure that was started before Your coverage ended.

SECTION XIII

Temporary Suspension Rights for Armed Forces' Members

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government, and
2. You serve no more than five (5) years of active duty.

You must make a written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premium will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XIV

General Provisions

1. Agreements between Us and Participating Providers.

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Policy does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any dental benefits program.

2. Assignment.

You cannot assign any benefits under this Policy to any person, corporation, or other organization. Any assignment of benefits by You will be void and unenforceable. Assignment means the transfer to another person, corporation or organization of Your right to the services provided under this Policy.

3. Changes in This Policy.

We may unilaterally change this Policy upon renewal, if We give You 45 days' prior written notice.

4. Choice of Law.

This Policy shall be governed by the laws of the State of New York.

5. Clerical Error.

Clerical error, whether by You or Us, with respect to this Policy, or any other documentation issued by Us in connection with this Policy, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. Conformity with Law.

Any term of this Policy which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. Continuation of Benefit Limitations.

Some of the benefits in this Policy may be limited to a specific number of visits, a benefit maximum, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Entire Agreement.

This Policy, including any endorsements, riders and the attached applications, if any, constitutes the entire Policy.

9. Furnishing Information and Audit.

All persons covered under this Policy will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Policy. You must provide Us with certain information over the telephone for reasons such as the following: to determine the level of care You need; so that We may certify care authorized by Your Provider, or make decisions regarding the medical necessity of Your care.

10. Identification Cards.

Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Policy. To be entitled to such services or benefits, Your Premiums must be paid in full at the time that the services are sought to be received.

11. Incontestability.

No statement made by the Subscriber in an application for coverage under this Policy shall void the Policy or be used in any legal proceeding unless the application or an exact copy is attached to this Policy. After two (2) years from the date of issue of this Policy, no misstatements, except for fraudulent misstatements made by the Subscriber in the application for coverage, shall be used to void the Policy or deny a claim.

12. Material Accessibility.

We will give You ID cards, Policies, riders and other necessary materials.

13. More Information about Your Dental Policy.

You can request additional information about Your coverage under this Policy. Upon Your request, We will provide the following information.

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines.
- Written application procedures and minimum qualification requirements for Providers.

14. Notice.

Any notice that We give You under this Policy will be mailed to Your address as it appears in Our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. Mail, first class, postage prepaid to the address on Your ID card.

15. Premium Payment

The first month's Premium is due and payable when You apply for coverage. Coverage will begin on the effective date of this Policy as defined herein. Subsequent Premiums are due and payable on the first of each month thereafter.

16. Premium Refund.

We will give any refund of Premiums, if due, to the Subscriber.

17. Recovery of Overpayments.

On occasion a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

18. Renewal Date.

The renewal date for the Policy is January 1 of each year. This Policy will automatically renew each year on the renewal date unless otherwise terminated by Us, as permitted by this Policy, or by the Subscriber upon 30 days' prior written notice to Us.

19. Reinstatement after Default.

If the Subscriber defaults in making any payment under this Policy, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Policy, but with respect to sickness and injury, only to Cover such sickness as may be first manifested more than 10 days after the date of such acceptance.

20. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Policy. Those standards will not be contrary to the descriptions in this Policy. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Policy.

21. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

22. Severability.

The unenforceability or invalidity of any provision of this Policy shall not affect the validity and enforceability of the remainder of this Policy.

23. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Policy and nothing in the Policy shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Policy. No other party can enforce this Policy's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Policy, or to bring an action or pursuit for the breach of any terms of this Policy.

24. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Policy. You must start any lawsuit against Us under this Policy within three (3) years from the date the claim was required to be filed.

25. Translation Services.

Translation services are available free of charge under this Policy for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

26. Waiver.

The waiver by any party of any breach of any provision of this Policy will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

27. Who May Change this Policy.

This Policy may not be modified, amended, or changed, except in writing and signed by Our President or a person designated by the President. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Policy in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the President or person designated by the President.

28. Who Receives Payment under this Policy.

Payments under this Policy for services provided by a Participating Provider will be made

directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.

29. Workers' Compensation Not Affected.

The coverage provided under this Policy is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

30. Your Dental Records and Reports.

In order to provide Your coverage under this Policy, it may be necessary for Us to obtain Your dental records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Policy, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your dental records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a dental professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a dental professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your dental records by Us.

We agree to maintain Your dental information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Policy, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

SECTION XV

PREFERRED PROVIDER ORGANIZATION DENTAL INSURANCE
SCHEDULE OF BENEFITS

The Guardian Life Insurance Company of America
A Mutual Company – Incorporated 1860 by the State of New York
10 Hudson Yards, New York, New York 10001

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
PEDIATRIC DENTAL CARE ESSENTIAL HEALTH BENEFIT			
Deductible			
• One (1) Member under Age 19	$60.00	$120.00	
• Two (2) or More Members under Age 19	$120.00	$240.00	
Out-of-Pocket Limit			
• One (1) Member under Age 19	$375.00	None	
• Two or More Members under Age 19	$750.00	None	
Annual and Lifetime Limits	None	None	

PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFIT & CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			
• Emergency Dental Care	0% Coinsurance after Deductible	0% Coinsurance after Deductible	One Dental Exam & Cleaning Per 6-Month Period
• Preventive Dental Care	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Routine Dental Care	50% Coinsurance after Deductible	50% Coinsurance after Deductible	Full mouth X-rays or panoramic X-rays at 36 month intervals and bitewing X-rays at 6 month intervals
• Endodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Periodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Prosthodontics	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Oral Surgery	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Orthodontics	50% Coinsurance after Deductible – see Limits	50% Coinsurance after Deductible – see Limits	

COST-SHARING **ADULT DENTAL CARE** **Other Covered Services** **Deductible** • Per Member • Three (3) or more covered Members (When 3 Insureds meet the Deductible, no additional Deductibles will be required to be met for that Benefit Year.) **Annual Maximum Per Covered Member** **Lifetime Maximum Benefit**	Participating Provider Member Responsibility for Cost-Sharing $60.00 $180.00 $1,000.00 None	Non-Participating Provider Member Responsibility for Cost-Sharing $120.00 $360.00 $1,000.00 None	
ADULT DENTAL CARE – Other Covered Services **Group I Services** **Group II Services**	Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance after Deductible 50% Coinsurance after Deductible – see Limits	Non-Participating Provider Member Responsibility for Cost-Sharing 0% Coinsurance after Deductible 50% Coinsurance after Deductible – see Limits	Please see the Limitations and Exclusions shown under Section VII of your Certificate of Coverage. There is a 6 month waiting period for Group II Services.