EXHIBIT 5 - Vol. 1

CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

Sanford Herman

Vice President, Group Pricing & Standards

CGP-3-R-STK-90-3

B110.0023-R

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IMPORTANT NOTICE

SECTION I The Dental benefits are directly funded through and provided by your employer, and are not insured by The Guardian. Your employer has the sole responsibility and liability for payment of Dental benefits.

All terms and provisions, maximums or limitations set forth in the Certificate Booklet will be applicable to the combined benefits provided by your employer.

B115.0113-R

An Important Notice About Continuation Rights

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

B235.0109-R

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

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

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

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security's determination of the disabled qualified continuee's disability before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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

Special Continuance for Retired Employees and their Dependents

If your group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the employer, you may elect to continue such benefits, provided that:

(a) you are or become a retired employee on or before the date group health benefits end; and

(b) you and your dependents were covered for group health benefits under this plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for your lifetime. After your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for you and your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If you die before the bankruptcy proceeding under Title 11 of the United States Code, your surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceedings. The continuation can last for your surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.

B235.0126-R

If You Die While Covered

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

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of dependent eligibility, as defined in this plan, of a covered dependent child.

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

B235.0119-R

Your Employer's Responsibilities

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

Election of Continuation

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

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

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

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

Grace in Payment

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

When Continuation Ends

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

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

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

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

(4) with respect to a dependent whose continuation is extended due to your entitlement to Medicare while the dependent is on continuation, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

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

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

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

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

B235.0124-R

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002-R

Employee Coverage

Eligible Employees

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

CGP-3-EC-90-1.0 B489.0131-R

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

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

If you are a *qualified retiree*, you can not be confined in a health care facility on the scheduled effective date of coverage. If you are confined on that date, we will postpone your coverage until the day after you are discharged. And you must also have met all of the applicable conditions of eligibility and any applicable waiting period in order for coverage to start.

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

CGP-3-EC-90-2.0 B489.0067-R

When Your Coverage Ends

If you are an active *full-time employee*, your coverage ends on the date your active *full-time* service ends for any reason, other than disability. Such reasons include death, retirement (except for *qualified retirees*), layoff, leave of absence and the end of employment. If you are a *qualified retiree*, your coverage ends at age 65.

If you are an active *full-time employee* or a *qualified retiree*, your coverage also ends on the date you stop being a member of a class of *employees* eligible for insurance under this *plan*, or when this *plan* ends for all *employees*. And it ends when this *plan* is changed so that benefits for the class of *employees* to which you belong ends.

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

CGP-3-EC-90-3.0 B489.0110-R

Continuation During A Family Leave Of Absence

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

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

Employee Coverage (Cont.)

Group insurance may end for you because you cease *full-time* work due to an approved leave of absence. Such leave of absence must have been granted to allow you to care for a seriously ill spouse, child or parent, or after the birth or adoption of a child, or due to your own serious health condition. If so, your group insurance will be continued. You will be required to pay the same share of the premium as before the leave of absence.

Insurance may continue until the earliest of: (a) the date you return to *full-time* work; (b) the end of a total leave period of 12 weeks in any 12 month period; (c) the date on which your coverage would have ended had you not been on leave; or (d) the end of the period for which the premium has been paid.

CGP-3-EC-90-3.0 B449.0036-R

Dependent Coverage

B200.0271-R

Eligible Dependents For Dependent Dental Benefits

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

CGP-3-DEP-90-2.0 B200.0515-R

Adopted And Step-Children

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

Dependents Not Eligible

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

CGP-3-DEP-91-3.1-NY B489.0003-R

Handicapped Children

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0 B449.0042-R

Waiver Of Dental Late Entrants Penalty

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

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

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

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

When Dependent Coverage Starts

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

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

If you do this within the *enrollment period,* the coverage is scheduled to start on the later of the date you sign the enrollment form; and the date you become insured for employee coverage.

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

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

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

CGP-3-DEP-90-6.0 B489.0060-R

Exception

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

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

Newborn And Adopted Children

We cover your newborn child for dependent benefits, from the moment of birth. We also cover your adopted child for dependent benefits from the moment of birth if you take physical custody of the child upon such child's release from the hospital and you file a petition for adoption within 30 days of the child's birth.

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

CGP-3-DEP-90-8.0 B489.0027-R

When Dependent Coverage Ends

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

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

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

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he or she marries, when a child covered as a student is no longer an active *full-time* student, or when a step-child is no longer dependent on you for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment. But, if a child who is enrolled as a *full-time* student must take a medical leave of absence from school due to sickness, his or her coverage may be continued. Such coverage may be continued for up to one year from the last day the child attended school, but not beyond the date coverage would otherwise end under this *plan* if he or she did not take the medical leave of absence; provided: (a) we receive a *doctor's* certification of the sickness which requires the leave of absence; (b) the group *plan* remains in force; and (c) all required premiums for the child's coverage continue to be paid.

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

CGP-3-DEP-90-9.0 B509.0032-R

CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner will be eligible for dental coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

Coverage for the domestic partner ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

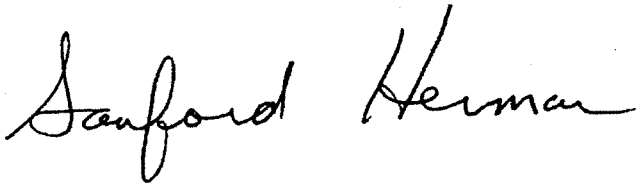
And, the domestic partner will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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

The Guardian Life Insurance Company of America



Vice President, Group Pricing & Standards

CGP-3-A-DMST-96

B210.0017-R

DENTAL HIGHLIGHTS

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

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

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

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

  For Group I, II and III Services . . . . . $50.00 for each covered person

B497.0069-R

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

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

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

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

B497.0089-R

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

  For Group I, II and III Services . . . . . Up to $2,000.00

- **Lifetime Payment Limit for Orthodontic Treatment**

  For Group IV Services . . . . . Up to $2,000.00

Open Enrollment

Once each year, during the group enrollment period from December 1st to December 31st, you may elect to enroll in dental insurance under this plan. Coverage starts on the January 1st that next follows enrollment. Late entrant/enrollee penalties do not apply to you and your eligible dependents if you enroll during this period.

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

DENTAL EXPENSE INSURANCE

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

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

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

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

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

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

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

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

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

CGP-3-DENT-PPO-A B490.0153-R

Covered Charges

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

By reasonable, we mean the charge is the *dentist's* usual charge for the service furnished. But if more than one type of service can be used to treat a dental condition, we have the right to consider charges for the least expensive one which meets the accepted standards of dental practice. By customary, we mean the charge made for the given dental condition isn't more than the usual charge made by most other *dentists* with similar training and experience in the same geographic area.

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

CGP-3-DNTL-90-3 B490.0038-R

Pre-Treatment Review

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

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

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

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

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

CGP-3-ASO-DTL-4-95 B497.0434-R

Benefits From Other Sources

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

CGP-3-ASO-DTL-5-95 B497.0437-R

The Benefit Provision - Qualifying For Benefits

Group I, II And III Non-Orthodontic Services

There is no deductible for Group I services provided by a PPO Provider. We pay for Group I *covered charges* from a PPO Provider at the applicable payment rate.

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

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

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

All charges must be incurred while the *covered person* is insured. We limit what we pay each *benefit year* to $2,000.00. What we pay is based on all of the terms of this *plan.*

CGP-3-DNTL-92-7 B497.0012-R

Group IV Orthodontic Services

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

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

We make the initial payment when the active *appliance* is first placed. We make further payments at the end of each subsequent three month period. But treatment must continue and the *covered person* must stay insured. We limit what we pay during a *covered person's* lifetime to $2,000.00. What we pay is based on all of the terms of this *plan.*

The Benefit Provision - Qualifying For Benefits (Cont.)

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

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

Non-Orthodontic Family Deductible Limit

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

CGP-3-DNTL-90-9 B490.0137-R

Payment Rates

Benefits for covered charges are paid at the following rates:

Benefits for Group I Services performed by a preferred provider are paid at a rate of	100%
Benefits for Group I Services performed by other providers are paid at a rate of	100%
Benefits for Group II Services performed by a preferred provider are paid at a rate of	90%
Benefits for Group II Services performed by other providers are paid at a rate of	80%
Benefits for Group III Services performed by a preferred provider are paid at a rate of	60%
Benefits for Group III Services performed by other providers are paid at a rate of	50%
Benefits for Group IV Services performed by a preferred provider are paid at a rate of	50%
Benefits for Group IV Services performed by other providers are paid at a rate of	50%

CGP-3-DRATE-90 B497.0038-R

After This Insurance Ends

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

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

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

Special Limitations

Penalty For Late Entrants

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

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

A late entrant is a person who: (1) becomes insured more than 31 days after he is eligible; or (2) becomes insured again, after his coverage lapsed because he did not make required payments.

CGP-3-DNTL-90-11.0 B490.0046-R

Teeth Lost Before A Covered Person Became Insured By This Plan

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

If This Plan Replaces Another Plan

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

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

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

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

CGP-3-DNTL-90-11.1 B490.0053-R

Exclusions

- We won't pay for:
  - Oral hygiene, plaque control or diet instruction.
  - Precision attachments.
- We won't pay for:
  - Treatment which does not meet accepted standards of dental practice.
  - Treatment which is experimental in nature.

Exclusions (Cont.)

- We won't pay for any *appliance* or *prosthetic device* used to:
  - Change vertical dimension.
  - Restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment.*
  - Splint or stabilize teeth for periodontic reasons.
  - Replace tooth structure lost as a result of abrasion or attrition.
  - Treat disturbances of the temporomandibular joint.
- We won't pay for any service furnished for cosmetic reasons. This includes, but is not limited to:
  - Characterizing and personalizing *prosthetic devices.*
  - Making facings on *prosthetic devices* for any teeth in back of the second bicuspid.
- We won't pay for replacing an *appliance* or *prosthetic device* with a like appliance or device, unless:
  - It is at least ten years old and can't be made usable.
  - It is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be fixed.
- We won't pay for:
  - Replacing a lost, stolen or missing *appliance* or *prosthetic device.*
  - Making a spare *appliance* or device.
- We won't pay for treatment needed due to:
  - An on-the-job or job-related injury.
  - A condition for which benefits are payable by Worker's Compensation or similar laws.
- We won't pay for treatment for which no charge is made. This usually means treatment furnished by:
  - The *covered person's employer,* labor union or similar group, in its dental or medical department or clinic.
  - A facility owned or run by any governmental body.
  - Any public program, except Medicaid, paid for or sponsored by any government body.

  But if a charge is made and we are legally required to pay it, we will.

List of Covered Dental Services

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

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

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluoride Treatments

Prophylaxis (limited to one treatment in any six consecutive month period) - Allowance includes the complete removal of explorer-detectable calculus, soft deposits, plaque, stains, and the smoothing of tooth surfaces above the gingival attachment.

Topical application of fluoride, including prophylaxis, (limited to *covered persons* under age 14 and limited to one treatment in any six consecutive month period).

Space Maintainers

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

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

Fixed And Removable Appliances

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

Diagnostic Services

Allowance includes examination and diagnosis - x-rays.

- Full mouth series of at least 14 films including bitewings, if needed (limited to once in any 60 consecutive month period).
- Bitewing films (limited to a maximum of four films, in one visit, in any twelve consecutive month period).
- Intraoral periapical or occlusal x-rays - single films.
- Extraoral superior or inferior maxillary film.
- Panoramic film, maxilla and mandible, allowable only when necessary to diagnose accidental injury, or in conjunction with cyst or tumor removal.

Dental Sealants

(Limited to the unrestored permanent molars of *covered persons* under age 16 and limited to one treatment in any 36 consecutive month period).

Office Visits And Examinations

Oral examination (limited to one examination in any six consecutive month period).

Emergency palliative treatment and other non-routine, unscheduled visits. We pay for this only if no other service (except x-rays) is rendered during the visit.

Group II - Basic Dental Services
(Non-Orthodontic)

Office Visits And Examinations

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

Diagnostic Services

Allowance includes examination and diagnosis.

- Diagnostic casts, when necessary to diagnose complex restorative cases.
- Biopsy and examination of oral tissue.

Restorative Services

Multiple restorations on one surface will be considered one restoration. Also see "Major Restorative Services". Allowance includes insulating base and local anesthesia.

- Amalgam restorations (primary or permanent teeth).
  - Cavities involving one surface, two surfaces and three or more surfaces.
- Synthetic restorations: Allowable includes curing light and etchant.
  - Anterior teeth - per restoration: Acrylic or plastic filling - Class I and III types; Composite resin - Class I and III types 2330; Composite resin - involving incisal angle.
  - Bicuspid teeth - Composite resin - Class V type.
- Crowns: Acrylic or plastic, without metal, and Stainless steel.
- Pins: Pin retention, exclusive of restorative material - used in lieu of cast restorations.
- Recementation: Inlay or onlay, Crown, and Bridge.

Endodontic Services

Allowance includes all endodontic treatment within 12 months.

- Pulp capping, direct, for full or new pulpal exposure.
- Remineralization (Calcium Hydroxide), as a separate procedure.
- Vital pulpotomy.
- Apexification, therapeutic apical closure.
- Root canal therapy on non-vital (nerve-dead) teeth. Allowance includes routine x-rays and cultures, but excludes final restoration.
  - Anterior, bicuspid, or molar teeth.
- Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures. Allowance includes retrograde filling.

Periodontic Services

Allowance includes the treatment plan, local anesthetics and post-operative care.

- Non-Surgical Services:
  - Periodontal root planing - As necessary for substantial bone and attachment loss (limited to one treatment per area in any 24 month period).
  - Occlusal adjustment - Allowable only when done in conjunction with periodontal surgery.

- Surgical Services (limited to one treatment per area in any 36 month period):
  - Gingivectomy, per tooth - Less than 3 teeth and not incidental to crown preparations.
  - Osseous surgery, per quadrant - Including all necessary (associated) surgical procedures.
  - Mucogingival Surgery (pedicle soft tissue graft, sliding horizontal flap, free soft tissue graft).

Oral Surgery

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

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

Other Surgical Procedures

- Alveolectomy, per quadrant.
- Stomatoplasty with ridge extension, per arch.
- Removal of mandibular tori, per quadrant.
- Excision of hyperplastic tissue.
- Excision of pericoronal gingiva, per tooth.
- Removal of palatal torus.
- Removal of cyst or tumor - not associated with the removal of impacted teeth.
- Incision and drainage of abscess.
- Closure of oral fistula or maxillary sinus.
- Reimplantation of tooth.
- Frenectomy.
- Suture of soft tissue injury.
- Sialolithotomy for removal of salivary calculus.
- Closure of salivary fistula.
- Dilation of salivary duct.
- Sequestrectomy for osteomyelitis or bone abscess, superficial.
- Maxillary sinusotomy for removal of tooth fragment or foreign body.

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Prosthodontic Services

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

- Denture repairs, acrylic: Repairing dentures, no teeth damaged; Repairing dentures and replace one or more broken teeth; and Replacing one or more broken teeth, no other damage.
- Denture repairs, metal - Allowance based on the extent and nature of damage and on the type of materials involved.
- Full or partial denture rebase, jump case (limited to once per denture in any 36 consecutive month period).
- Full or partial denture reline (limited to once per denture in any 12 consecutive month period): Office reline; Cold cure; Laboratory reline.

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

- Denture adjustments (limited to adjustments by a dentist other than the one providing the denture, and adjustments are more than 6 months after the initial installation).
- Tissue conditioning (limited to a maximum of 2 treatments per arch in any 12 consecutive month period).
- Adding teeth to partial dentures to replace extracted natural teeth.
- Repairs to crowns and bridges - allowance based on the extent and nature of damage and the type of materials involved).

Other Services

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

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Group III - Major Dental Services
(Non-Orthodontic)

Restorative Services

Cast restorations and crowns are covered only when needed because of decay or *injury,* and only when the tooth cannot be restored with a routine filling material. Allowance includes insulating bases, temporization and minor associated gingival involvement. Also see "Basic Restorative Services".

- Inlays.
- Onlays, in the presence of an inlay.
- Crowns and Posts: Acrylic with metal. Porcelain, Porcelain with metal, Full cast metal (other than stainless steel), 3/4 cast metal (other than stainless steel), Cast post and core, in addition to crown (not a thimble coping), Steel post and composite or amalgam core, in addition to crown, and Cast dowel pin (one-piece cast with crown) - Allowance based on type of crown, Crown build-up - Necessitated by loss of natural tooth structure.

Prosthodontic Services

Specialized technique and characterizations are not covered. Also see "Basic Prosthodontic Services".

- Fixed bridges - Each abutment and each pontic makes up a unit in a bridge.
- Bridge abutments - See inlays and crowns under "Major Restorative Services".
- Bridge Pontics: Cast metal, sanitary, Plastic or porcelain with metal, and Slotted pontic.
- Simple stress breakers, per unit.

Group III - Major Dental Services (Cont.)
(Non-Orthodontic)

- Dentures - Allowance includes all adjustments done by the *dentist* furnishing the denture in the first 6 months after installation. Temporary dentures older than one year are considered to be a permanent appliance.
  - Full dentures, upper or lower.
  - Partial dentures - Allowance includes base, all clasps, rests and teeth.
    - Unilateral, one piece chrome casting, clasp attachment, including pontics.
    - Upper, with two chrome clasps with rests, acrylic base.
    - Upper, with chrome palatal bar and clasps, acrylic base.
    - Lower, with two chrome clasps with rests, acrylic base.
    - Lower, with chrome lingual bar and clasps, acrylic base.
    - Stayplate base, upper or lower (anterior teeth only).

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Group IV - Orthodontic Services

Orthodontic Services

- Any Group I, II or III service in connection with *orthodontic treatment.*
- Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes routine x-rays, local anesthetics and post-surgical care.
- Active *appliances* - All types - Allowance includes diagnostic services, the treatment plan, the fitting, making and placing of the active *appliance,* and all related office visits including post-treatment stabilization.

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

COORDINATION OF BENEFITS

Important Notice

This provision applies to all health expense benefits under this plan. It does not apply to death, dismemberment, or loss of income benefits.

Purpose Of This Provision

An employee may be covered for health expense benefits by more than one plan. For instance, he may be covered by this plan as an employee and by another plan as a dependent of his spouse. If he is, this provision allows us to coordinate what we pay with what another plan pays. We do this so the covered person doesn't collect more in benefits than he incurs in charges.

Definitions

"We" and "our" mean The Guardian Life Insurance Company of America.

"Plan" means any of the following that provides health expense benefits or services: (a) group or blanket insurance plans; (b) group Blue Cross plans, group Blue Shield plans, or other service or prepayment plans on a group basis; (c) union welfare plans, employer plans, employee benefits plans, trusteed labor and management plans, or other plans for members of a group; and (d) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other government program or coverage which we are not allowed to coordinate with by law. Plan also does not include blanket school accident-type coverage. Nor does it include any plan we say we supplement. Plans that we supplement are named in the schedule.

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

"Member" means the person who receives a certificate or other proof of coverage from a plan that covers him for health expense benefits.

"Dependent" means a person who is covered by a plan for health expense benefits, but not as a member.

"Allowable expense" means any necessary, reasonable, and usual expense for health care incurred by a member or dependent under both this plan and at least one other plan. When a plan provides service instead of cash payment, we view the reasonable cash value of each service as an allowable expense and as a benefit paid. We also view benefits payable by another plan as an allowable expense and as a benefit paid, whether or not a claim is filed under that plan.

The difference between the cost of a private hospital room and the cost of a semi-private hospital room is not considered an allowable expense unless the covered person's stay in a private hospital room is medically necessary in terms of generally accepted medical practice.

"Claim determination period" means a calendar year in which a member or dependent is covered by this plan and at least one other plan and incurs one or more allowable expense under such plans.

How This Provision Works

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

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

If a plan has no coordination provision, it is primary. But, during any claim determination period, when this plan and at least one other plan have coordination provisions, the rules that govern which plan pays first are as follows:

(A) A plan that covers a person as a member pays first; the plan that covers a person as a dependent pays second;

(B) Except for dependent children of separated or divorced parents, the following governs which plan pays first when the person is a dependent of a member:

A plan that covers a dependent of a member whose birthday falls earliest in the calendar year pays first. The plan that covers a dependent of a member whose birthday falls later in the calendar year pays second. The member's year of birth is ignored.

If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.

But, if the plan that we're coordinating with does not have a similar provision for such persons, then (B) will not apply and the other plan's coordination provision will determine the order of benefits.

(C) For a dependent child of separated or divorced parents, the following governs which plan plays first when the person is a dependent of a member:

(1) When a court order makes one parent financially responsible for the health care expenses of the dependent child, then that parent's plan pays first;

(2) If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and

(3) The plan of the stepparent with custody pays before the plan of the natural parent without custody.

(D) A plan that covers a person as an active employee or as dependent of such employee pay first. A plan that covers a person as a laid-off or retired employee or as a dependent of such employee pays second.

But, if the plan that we're coordinating with does not have a similar provision for such persons, then (D) will not apply.

If rules (A), (B), (C), and (D) don't determine which plan pays first, the plan that has covered the person for the longer time pays first.

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

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

If, when we apply this provision, we pay less than we would otherwise pay, we apply only that reduced amount against payment limits of this plan.

Our Right To Certain Information

In order to coordinate benefits, we need certain information. An employee must supply us with as much of that information as he can. But if he can't give us all the information we need, we have the right to get this information from any source. And if another insurer needs information to apply its coordination provision, we have the right to give that insurer such information. If we give or get information under this section, we can't be held liable for such action except as required by Article 25 of the New York General Business Law.

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

Small Claims Waiver

We don't coordinate payments on claims of less than $50.00. But if, during any claim determination period, more allowable expenses are incurred that raise the claim above $50.00, we'll count the entire amount of the claim when we coordinate.

CERTIFICATE AMENDMENT

This plan is amended so that if a covered person is injured because of a third party's wrongful act or negligence:

- we will pay medical, dental or loss of earnings benefits for the injury, to the extent otherwise covered by this plan, if the covered person: (a) agrees in writing to The Guardian being subrogated to any recovery or right of recovery the covered person has against that third party; (b) does not take any action which would prejudice our subrogation rights; and (c) cooperates in doing what is reasonably necessary to assist us in any recovery;
- we will be subrogated only to the extent of benefits paid by this plan because of that injury; and
- we will be subrogated only when the amounts (or portion) received by the covered person through a third party settlement or satisfied judgment is specifically identified as amounts paid as benefits under this plan.

As used in this rider:

"Subrogation" means our right to recover any benefit payments made under this plan:

- because of an injury to a covered person caused by a third party's wrongful act or negligence; and
- which the covered person later recovers from the third party or the third party's insurer.

"Third Party" means any person or organization other than The Guardian, the employer or the covered person.

Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this certificate.

The Guardian Life Insurance Company of America

Sanford Herman

Vice President, Group Pricing & Standards

CGP-3-SUBR-NY-92

B600.0004-R

REQUIRED DISCLOSURE STATEMENT

For Group Plan No.: G -00298282-JC

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

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

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

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

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