



YOUR GROUP INSURANCE PLAN BENEFITS

HILTON WATERFRONT BEACH RESORT

CLASS 0002

AD&D, OPTIONAL LIFE, DENTAL, LIFE, VISION

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

The Guardian Life Insurance Company of America

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM

B999.0042

This Booklet Includes All Benefits For Which You Are Eligible.

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

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

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian

*10 Hudson Yards
New York, New York 10001*

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

CGP-3-R-STK-90-3

B110.0023

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SECTION I: Non-Managed DentalGuard Insurance

This part of your booklet does not apply to your plan of Managed DentalGuard dental care expense insurance.

Your Managed DentalGuard dental care expense insurance plan appears later in this booklet.

B850.0181

COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the Guardian at the following address or phone number:

**The Guardian Sales Office
801 Parkview Drive North, Suite 100
El Segundo, CA 90245
Telephone: (310) 765-2200
(800) 225-3399
Fax: (310) 765-2040**

If you feel your complaints have not been resolved after contacting the Guardian you may contact the California Department of Insurance at the following address or phone number:

**Department of Insurance
300 South Spring St.
Los Angeles, CA 90013**

**Consumer Hotline: 1-800-927-4357
Website: www.insurance.ca.gov/01-consumers/**

All Options

Dental Services Not Covered By This Plan **IMPORTANT:** If you opt to receive dental services that are not covered services under this plan, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at 1-888-618-2016 or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

CGP-3-CADISC

B120.0074

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0002

Limitation of Authority

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

CGP-3-R-LOA-90

B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-96

B160.0061

Examination and Autopsy

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

CGP-3-R-EA-90

B160.0006

Accident and Health Claims Provisions

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

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

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

Accident and Health Claims Provisions (Cont.)

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

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

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

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

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

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

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

CGP-3-R-AHC-90

B160.0005

Coordination Between Continuation Sections

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

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

CGP-3-R-COC-87

B240.0044

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87

B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

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

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

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

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

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

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

CGP-3-R-COBRA-96-1

B235.0631

All Options

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

CGP-3-R-COBRA-96-2

B235.0075

All Options

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

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

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

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

Federal Continuation Rights (Cont.)

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

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

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

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

CGP-3-R-COBRA-96-3

B235.0178

All Options

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

Federal Continuation Rights (Cont.)

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;
- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

B235.0198

Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4

B235.0195

ELIGIBILITY FOR LIFE COVERAGES

B264.0002

Employee Coverage

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

Other Conditions You must:

- (a) be legally working in the United States.
- (b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:
 - (i) your *employer's* place of business;
 - (ii) some place where your *employer's* business requires you to travel; or
 - (iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan*, provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved in writing.

If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof*. You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

CGP-3-EC-90-1.0

B264.0892

All Options

When Your Coverage Starts Employee benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, your effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0

B264.3210

All Options

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

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

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

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

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0

B264.0697

All Options

Your Right To Continue Group Life Insurance During A Family Leave Of Absence

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

Continuation of Coverage Life insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

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

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

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.

- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan*.
- The end of the period for which the premium has been paid.

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

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

CGP-3-EC-90-3.0

B264.2452

All Options

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90

B265.0002

All Options

Employee Basic Term Life Insurance

CGP-3-R-SCH-90

B265.0003

All Options

Your Basic Term Life Insurance Amount	Insurance Amount	\$20,000.00
	CGP-3-R-SCH-90	B265.0011

All Options

**Reduction of Basic
Life Insurance
Amount Based on
Age**

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's basic life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90

B265.0483

LIFE INSURANCE

B270.0070

All Options

Your Group Term Life Insurance

Basic Life Benefit If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.

Proof of Death We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your *employer* written notice, unless you've assigned this insurance. But the change won't take effect until your *employer* gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask your *employer* for details or write to us.

Payment to a Minor or Incompetent If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Settlement Option If you or your beneficiary ask us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-LB-90

B270.0113

Portability Privilege

Applicability	This provision applies only to this plan's employee Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.
Important Restriction	You must provide proof of insurability satisfactory to us.
Portability Of Basic Group Term Life Insurance	You may elect to continue all or part of your employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms. You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees. You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit. You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan. You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least \$50,000.00.
The Portable Certificate Of Coverage	You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan. The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.
How To Port	To get a portable certificate of coverage, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.
Defined Term	As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00

B270.0390

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95

B270.0326

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

Converting This Group Term Life Insurance

If Employment or Eligibility Ends Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends or Group Life Insurance Is Dropped Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

Converting This Group Term Life Insurance (Cont.)

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) \$2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How and When to Convert To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During the Conversion Period If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

Converting This Group Term Life Insurance (Cont.)

Notice of Conversion Right If you are entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA

B275.0217

All Options

Your Extended Life Benefit With Waiver Of Premium

Important Notice This section applies to your basic life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent basic life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your basic life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

- (a) not able to perform any work for wages or profit; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

Continued Eligibility For Extended Life Benefit We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or
- (b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

When This Extension Begins Once approved by us, your extended benefit will be effective on the later of:

- (a) 09 continuous months from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

CGP-3-R-LW-TD-99-1

B275.0513

All Options

- When This Extension Ends** Your extension will end on the earliest of:
- (a) the date you are no longer disabled;
 - (b) the date we ask you to be examined by our doctor, and you refuse;
 - (c) the date you do not give us the proof of disability we require;
 - (d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or
 - (e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death We'll pay as soon as we receive

- (a) written proof of your death, that is acceptable to us; and
- (b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2

B275.0059

Option E

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Option E

Employee Coverage

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

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

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

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

CGP-3-EC-90-1.0

B489.0122

Option E

Dental Plan Election Procedures Since Managed DentalGuard is offered to you as an alternative to this dental coverage, you may change your election, and enroll in Managed DentalGuard as follows.

If you drop your coverage under this *plan*, at any time other than during an open enrollment period, you may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If you remain covered under this plan, you may change your election, and enroll in Managed DentalGuard during an open enrollment period. Your coverage under this *plan* ends on the date coverage under Managed DentalGuard begins.

An "open enrollment period" is a 30 day period occurring once every 12 months after this plan's effective date, or at time intervals agreed upon by the *employer* and us.

If you change your election, your covered dependents will automatically be switched to Managed DentalGuard at the same time as you.

CGP-3-EC-90-1.0

B489.0137

Option E

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

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

CGP-3-EC-90-2.0

B489.0070

Option E

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B489.0075

Option E

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

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

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

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

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

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

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

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

- **Next Of Kin:** This term means the nearest blood relative of the *employee*.
- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

Coverage During a Temporary Leave If your active full-time service ends because you are disabled by pregnancy, childbirth or a related medical condition you may continue your coverage for up to four months during any twelve consecutive months.

Your employer may recover from you any premium paid if: 1) you fail to return from leave after four months; and 2) your failure to return is for a reason other than one of the following: (a) your taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles you to leave is beyond your control; or (c) if your employer is a state agency, the collective bargaining agreement will govern.

CGP-3-EC-90-3.0 B489.0628

Option E

Dependent Coverage

B200.0271

Option E

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

CGP-3-DEP-90-2.0 B489.0460

Option E

Adopted Children And Step-Children Your "dependent children" include your legally adopted children and, your step-children.

We treat a child as legally adopted from the time the child is placed in your physical custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover your adopted child from the moment of his or her placement if you are already covered for dependent child coverage when the child is placed for adoption. If you do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If you fail to do this, the child's coverage will end at the end of the 31 days. The child won't be covered by this plan again until you enroll the child. Then the child will be covered as of the date you sign the enrollment form and will be a late entrant and subject to any applicable late entrant penalties.

If this plan has pre-existing restrictions, they will not apply to a minor child adopted by you after this plan starts.

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

CGP-3-DEP-90-3.1

B489.0499

Option E

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

Option E

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

Option E

When Dependent Coverage Starts

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

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

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

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

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

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

CGP-3-DEP-90-6.0

B489.0055

Option E

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

Option E

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

CGP-3-DEP-90-8.0

B489.0232

Option E

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

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

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

Dependent Coverage (Cont.)

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

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

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

CGP-3-DEP-90-9.0

B489.0465

CERTIFICATE AMENDMENT

Effective September 1, 2007, this rider amends the dependent coverage provisions as follows:

Your domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with you in an intimate and committed relationship of mutual caring.

To qualify for such coverage, you and your domestic partner must be either:

- (a) registered domestic partners; or
- (b) non-registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

"Non-registered domestic partners" means an employee and his or her domestic partner who:

- are 18 years of age or older;
- are unmarried, constitute each other's sole domestic partner, and have not 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;
- are not related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- are 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.

Your registered domestic partner, or non-registered domestic partner, will be eligible for dental coverage under this plan.

To cover your non-registered domestic partner, you must complete a "Declaration of Domestic Partnership" attesting to the relationship and forward it to us.

A registered or non-registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

Coverage for a non-registered domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a non-registered domestic partner as described above. Upon termination of a non-registered domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once you submit a "Statement of Termination", you may not enroll another non-registered domestic partner for a period of 12 months from the date of the previous termination.

A non-registered domestic partner and his or her children will not be eligible for:

- (a) survivor benefits upon your death as explained under the "When Dependent' Coverage Ends" section;
- (b) continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless you are also eligible for and elect continuation.

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of dental coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if you are also eligible for and elect continuation.

Certificate Amendment (Cont.)

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

A handwritten signature in black ink, appearing to read "Michael Estep", with a stylized flourish at the end.

Michael Estep, Vice President

CGP-3-A-DMST-CA-05

B489.0223

Option E

DENTAL HIGHLIGHTS

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

- **PPO Benefit Year Cash Deductible for Non-Orthodontic Services**
For Group I Services None
For Group II and III Services \$50.00
for each covered person
- **Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services**
For Group I Services None
For Group II and III Services \$50.00
for each covered person

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

Option E

- **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%

CGP-3-DENT-HL-90 B497.0089

Option E

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

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

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

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

- **Lifetime Payment Limit for Orthodontic Treatment**

For Group IV Services Up to \$1,000.00

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

CGP-3-DENT-HL-90

B497.1434

Option E

**DentalGuard
Preferred Plus**

Benefits for services provided by a preferred provider in the plus program ("DentalGuard Preferred Plus Providers") will be reimbursed based on the non-preferred provider (Non-PPO) payment rates, deductibles, benefit year and lifetime payment limits, frequency and age limitations, coverages and exclusions.

CGP-3-DENT-HL-90

B497.2458

Option E

**Group Enrollment
Period**

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

CGP-3-DENT-HLTS

B497.2411

Option E

DENTAL EXPENSE INSURANCE

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

CGP-3-DG2000

B498.0007

Option E

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 are under contract with *Guardian's dental preferred provider organization (PPO)*, which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider*. Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider*.

When an *employee* enrolls in this *plan*, he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers*.

A *covered person* must present his or her ID card when he or she uses 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, but any benefit payable by us is sent directly to the *preferred provider*.

What we pay is based on all of the terms of this *plan*. Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits*.

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan*.

CGP-3-DGY2K-PPO

B498.0151

Covered Charges

If a *covered person* uses the services of a *preferred provider*, covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

If a *covered person* uses the services of a *non-preferred provider*, covered charges are reasonable and customary charges for the dental services listed in this *plan's* List of Covered Dental Services.

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

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

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

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

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

CGP-3-DGY2K-CC

B498.0066

Option E

Alternate Treatment

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

Proof Of Claim

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

CGP-3-DGY2K-AT

B498.1141

Option E

Pre-Treatment Review

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

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

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

Pre-Treatment Review (Cont.)

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

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

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

CGP-3-DGY2K-PTR

B498.0003

Option E

Benefits From Other Sources

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

CGP-3-DGY2K-OS

B498.0005

Option E

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN

B498.0072

Option E

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

- All Group II Services.

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

- All Group III Services.

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

- All Group IV Services.

The Benefit Provision - Qualifying For Benefits (Cont.)

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

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

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

CGP-3-DGY2K-LE

B498.0231

Option E

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

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

A *benefit year* deductible of \$50.00 applies to Group II and III services provided by a *preferred provider*. A *benefit year* deductible of \$50.00 applies to Group II and III services provided by a *non-preferred provider*. 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 the *covered person* 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 the deductible, we pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year*.

CGP-3-DGY2K-BP

B498.0177

Option E

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$1,500.00 for the services of a *preferred provider*, and \$1,000.00 for the services of a *non-preferred provider*.

Benefits applied to a *covered person's* Non-PPO *benefit year payment limit* are also applied to his or her PPO *benefit year payment limit*. And benefits applied to a covered person's PPO *benefit year payment limit* are also applied to his or her Non-PPO *benefit year payment limit*.

CGP-3-DGY2K-BP

B498.0191

Option E

The Benefit Provision - Qualifying For Benefits

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

CGP-3-DG-ROLL-04-2.1 B498.2041

Option E

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

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

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

Note: If all of the benefits that a *covered person* receives in a *benefit year* are for services provided by a *preferred provider*, he or she may be entitled to a greater *Reward* than if any of the benefits are for services of a *non-preferred provider*.

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

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

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

- *Rollover Threshold* \$500.00
- *Reward* (if all benefits are for services provided by a *preferred provider*) \$350.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider*) \$250.00
- *Bank Maximum* \$1,000.00

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

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

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

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

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

Definitions of terms used in this provision:

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

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

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

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

CGP-3-DG-ROLL-04-2

B498.9137

Option E

How We Pay Benefits For Group IV Orthodontic Services

This *plan* provides benefits for Group IV orthodontic services.

We pay for Group IV covered charges at the applicable *payment rate*. There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider*.

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

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

The Benefit Provision - Qualifying For Benefits (Cont.)

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

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

The negotiated discounted fees for orthodontics performed by a *preferred provider* include: (a) treatment *plan* and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment*, with associated: (i) fabrication and insertion of any and all fixed *appliances*; and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic *appliances* made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, *appliances* or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in *orthodontic treatment* necessitated by any kind of accident; (d) replacement or repair of orthodontic *appliances* damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate orthodontic treatment; and (g) *orthodontic treatment* started before the member was eligible for orthodontic benefits under this *plan*.

Whether or not a charge is based on a discounted fee, it will be counted toward a *covered person's* orthodontic lifetime payment limit under this *plan*.

CGP-3-DGY2K-OR

B498.0057

Option E

Non-Orthodontic Family Deductible Limit

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

CGP-3-DGY2K-FL

B498.0073

Option E

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

- Benefits for Group I Services performed by
a *preferred provider* 100%
- Benefits for Group I Services performed by
a *non-preferred provider* 100%
- Benefits for Group II Services performed by
a *preferred provider* 90%
- Benefits for Group II Services performed by
a *non-preferred provider* 80%
- Benefits for Group III Services performed by
a *preferred provider* 60%
- Benefits for Group III Services performed by
a *non-preferred provider* 50%
- Benefits for Group IV Services performed by
a *preferred provider* 50%
- Benefits for Group IV Services performed by
a *non-preferred provider* 50%

CGP-3-DGY2K-PR B498.0080

Option E

After This Insurance Ends

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

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

CGP-3-DGY2K-END B498.0233

Option E

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Option E

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan*. We won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan*.

CGP-3-DGY2K-TL

B498.0133

Option E

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

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

CGP-3-DGY2K-PP

B498.0129

Option E

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.

Exclusions (Cont.)

- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *appliance* or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis*; or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Pulp vitality tests; or caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances*. But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis*; and (2) odontoplasty.

Exclusions (Cont.)

- Replacing an existing appliance or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations; or the replacement of congenitally missing teeth
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic *appliance*.
- The replacement of a lost or broken orthodontic retainer.

CGP-3-DGY2K-EXCH-01

B498.2173

Option E

List of Covered Dental Services

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

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

CGP-3-DNTL-90-13

B490.0048

Option E

Group I - Preventive Dental Services (Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of 1 prophylaxis or periodontal maintenance procedure (considered under "Periodontal Services") in any 6 consecutive month period. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

Office visits, oral evaluations, examinations or limited problem focused re-evaluations - limited to a total of 1 in any 6 consecutive month period.

Emergency or problem focused oral evaluation - limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed in the same visit.

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

CGP-3-DNTL-90-14

B498.4803

Option E

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

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

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

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

CGP-3-DNTL-90-14

B498.0164

Option E

Radiographs Allowance includes evaluation and diagnosis. Also see BASIC DENTAL SERVICES, Radiographs.

- Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, once in any 12 consecutive month period.

CGP-3-DNTL-90-14

B498.2042

Option E

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

CGP-3-DNTL-90-14

B498.0166

Option E

Group II - Basic Dental Services (Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

Group II - Basic Dental Services (Cont.)

(Non-Orthodontic)

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures - limited to one test in any 24 consecutive month period for covered persons age 40 and older.

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

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations on *anterior teeth* that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration
Composite resin

Stainless steel prefabricated resin, and resin based composite - limited to once per tooth in any 24 consecutive month period. Stainless steel, prefabricated resin 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.

CGP-3-DNTL-90-15

B498.2765

Option E

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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

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

Inlay or onlay

Crown

Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

Denture repairs, metal

Denture repairs, acrylic

Denture repair, no teeth damaged

Denture repair, replace one or more broken teeth

Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture rebases done within 12 months are considered to be part of the denture placement when the rebase is done by the *dentist* who furnished the denture. Limited to rebase done more than 12 consecutive months after the insertion of the denture.

Denture reline, full or partial denture - limited to once per denture in any 24 consecutive month period. Denture relines done within 12 months are considered to be part of the denture placement when the reline is done by the *dentist* who furnished the denture. Limited to reline done more than 12 consecutive months after a denture rebase or the insertion of the denture.

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

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

CGP-3-DNTL-90-15

B498.1122

Option E

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

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

Pulp capping, direct

Pulp capping, indirect - includes sedative filling.

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

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only

Endodontic Therapy

Root canal therapy on anterior and bicuspid teeth

Root canal retreatment on anterior and bicuspid teeth, limited to once per tooth, per lifetime

Treatment of root canal obstruction, no-surgical access

Incomplete endodontic therapy, inoperable or fractured tooth

Internal root repair of perforation defects

Other Endodontic Services

Apexification, limited to a maximum of three visits

Apicoectomy, limited to once per root, per lifetime

Root amputation, limited to once per root, per lifetime

Retrograde filling, limited to once per root, per lifetime

Hemisection, including any root removal, once per tooth

CGP-3-DNTL-90-15.0

B498.2044

Option E

Periodontal Services Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of 1 prophylaxis or periodontal maintenance procedure(s) in any 6 consecutive month period. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once in any 36 consecutive month period. Considered only when no diagnostic, preventive, periodontal service or periodontal surgery procedure has been performed in the previous 36 consecutive month period.

CGP-3-DNTL-90-15.0

B498.0202

Option E

Periodontal Surgery Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

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

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

Gingivectomy or gingivoplasty, per quadrant
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
Gingival flap procedure, including scaling and root planing, per quadrant
Distal or proximal wedge, not in conjunction with osseous surgery
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.

Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

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

Periodontal surgery related

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

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

CGP-3-DNTL-90-15.0

B498.0203

Option E

Radiographs Allowance includes evaluation and diagnosis. Also see PREVENTIVE DENTAL SERVICES, Radiographs

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 films including bitewings
- Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

- Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-15.0

B498.2043

Option E

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

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

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

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

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

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

CGP-3-DNTL-90-15.0

B498.1124

Option E

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

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15

B498.0206

Group III - Major Dental Services
(Non-Orthodontic)

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

Single Crowns

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

Inlays

- Onlays, including inlay
- Labial veneers

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

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

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

Crown or core buildup, including pins

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

Abutment supported crown

Implant supported crown

Abutment supported retainer for fixed partial denture

Implant supported retainer for fixed partial denture

Implant/abutment supported removable denture for completely edentulous arch

Implant/abutment supported removable denture for partially edentulous arch

Implant/abutment supported fixed denture for completely edentulous arch

Implant/abutment supported fixed denture for partially edentulous arch

Dental implant supported connecting bar

Prefabricated abutment

Custom abutment

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

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

Surgical placement of implant body, endosteal implant

Surgical placement, eposteal implant

Surgical placement, transosteal implant

Other Implant services

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

Radiographic/surgical implant index - limited to once per arch in any 24 month period

Repair implant supported prosthesis

Repair implant abutment

Implant removal

CGP-3-DNTL-90-16

B498.1148

Option E

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

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

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

Bridge Pontics

Resin with metal

Porcelain

Porcelain with metal

Full cast metal

3/4 cast metal crowns

3/4 porcelain crowns

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

CGP-3-DNTL-90-16

B498.1146

Option E

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

Endodontic Therapy

Root canal therapy on molar teeth

Root canal retreatment on molar teeth, limited to once per tooth, per lifetime

CGP-3-DNTL-90-16

B498.2045

Group IV - Orthodontic Services

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

Transseptal fiberotomy

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

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

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

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

CGP-3-DNTL-90-8

B498.0071

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

Employee Vision Care Expense Coverage

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

Other Conditions You must enroll and agree to make required payments within 31 days of your *eligibility date*. If you fail to do so, you can't enroll until this *plan's* next vision open enrollment period.

This *plan's* vision open enrollment period occurs from August 1st to August 31st of each year.

Once you enroll in this *plan*, you can't drop your vision coverage until this *plan's* next vision open enrollment period. And if you drop your vision coverage, you can't enroll again until the next vision open enrollment period.

If you initially waived vision coverage under this *plan* because you were covered for vision care benefits under another group plan, and you wish to enroll in this *plan* because your coverage under the other plan ends, you may do so without waiting until the next vision open enrollment period. However, your coverage under the other plan must have ended due to one of the following events: (a) termination of your spouse's employment; (b) loss of eligibility under your spouse's plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan. But you must enroll in this *plan* within 30 days of the date that any of these events occur.

CGP-3-EC-90-1.0

B505.0060

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

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

CGP-3-EC-90-2.0

B505.1681

All Options

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B505.0083

All Options

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

Coverage During a Temporary Leave If your active full-time service ends because you are disabled by pregnancy, childbirth or a related medical condition you may continue your coverage for up to four months during any twelve consecutive months.

Your employer may recover from you any premium paid if: 1) you fails to return from leave after four months; and 2) your failure to return is for a reason other than one of the following: (a) your taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles you to leave is beyond your control; or (c) if your employer is a state agency, the collective bargaining agreement will govern.

CGP-3-EC-90-3.0

B505.1449

All Options

Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

All Options

Eligible Dependents For Dependent Vision Care Benefits

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

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

CGP-3-DEP-90-2.0

B505.0782

All Options

Adopted Children And Step-Children

Your "unmarried dependent children" include your 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 your physical custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover your adopted child from the moment of his or her placement if you are already covered for dependent child coverage when the child is placed for adoption. If you do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If you fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

Dependents Not Eligible

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

CGP-3-DEP-90-3.1

B505.0537

All Options

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

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

B505.0119

All Options

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

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

If you do this after the *enrollment period* ends, you can't enroll your *initial dependents* until the next vision open enrollment period.

Once you have coverage for your *initial dependents*, you must notify us when you acquire any new dependents, and agree to make any additional payments required for the 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 becomes eligible. If you fail to notify us on time, you can't enroll the *newly acquired dependent* until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can't be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can't be enrolled again until the next vision open enrollment period.

CGP-3-DEP-90-6.0

B505.0130

All Options

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

CGP-3-DEP-90-7.0

B505.0132

All Options

Newborn Children We cover your newborn child from the moment of birth if you are already covered for dependent child coverage when the child is born. If you do not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of his or her birth. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child's coverage will end at the end of the 31 days, and the child cannot be enrolled for this coverage until the plan's next open enrollment period.

CGP-3-DEP-90-8.0

B505.0538

All Options

When Dependent Coverage Ends Dependent coverage ends for all of your dependents when your employee coverage ends. But if you die while insured, we'll automatically continue dependent vision care benefits for those of your dependents who are insured when you die. 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 dependent vision care benefits under this *plan's* "Federal Continuation Rights" provision, or under any other continuation provision of this *plan*, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

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

Dependent Vision Care Expense Coverage (Cont.)

If you are required to pay 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 stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the *employee* for support and maintenance. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

B505.0746

CERTIFICATE AMENDMENT

Effective September 1, 2007, this rider amends the dependent coverage provisions as follows:

Your domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with you in an intimate and committed relationship of mutual caring.

To qualify for such coverage, you and your domestic partner must be either:

- (a) registered domestic partners; or
- (b) non-registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

"Non-registered domestic partners" means an employee and his or her domestic partner who:

- are 18 years of age or older;
- are unmarried, constitute each other's sole domestic partner, and have not 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;
- are not related by blood to a degree that would prohibit marriage in the employee's state of residence; and

- are 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.

Your registered domestic partner, or non-registered domestic partner, will be eligible for vision coverage under this plan.

To cover your non-registered domestic partner, you must complete a "Declaration of Domestic Partnership" attesting to the relationship and forward it to us.

A registered or non-registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

Coverage for a non-registered domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a non-registered domestic partner as described above. Upon termination of a non-registered domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once you submit a "Statement of Termination", you may not enroll another non-registered domestic partner for a period of 12 months from the date of the previous termination.

A non-registered domestic partner and his or her children will not be eligible for:

- (a) survivor benefits upon your death as explained under the "When Dependent' Coverage Ends" section;
- (b) continuation of vision coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless you are also eligible for and elect continuation.

Certificate Amendment (Cont.)

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of vision coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if you are also eligible for and elect 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

A handwritten signature in black ink, appearing to read "Michael Estep", with a stylized flourish at the end.

Michael Estep, Vice President

CGP-3-A-DMST-CA-05

B505.0540

All Options

VISION CARE HIGHLIGHTS

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

PPO Copayments	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Contact Lenses	\$25.00
Non-PPO Cash Deductibles	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Contact Lenses	\$25.00

CGP-3-VSN-96-BEN3 B505.0519

All Options

If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan's materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.

CGP-3-VSN-96-BEN3 B505.0516

VISION CARE BENEFITS

This insurance will pay many of an *employee's* and his or her covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

CGP-3-DAVIS-05-VIS

B505.0466

This Plan's Vision Care Preferred Provider Organization

Davis Vision: This *plan* is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Davis Vision's Preferred Provider Network.

This vision care *preferred provider* organization (PPO) is made up of *preferred providers* in a *covered person's* geographic area. A vision care *preferred provider* is a vision care practitioner or a vision care facility that: (a) is a credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from either a *preferred provider* or a *non-preferred provider*. And, he or she is free to change providers at any time. But, this *plan* usually pays more in benefits for covered services furnished by a vision care *preferred provider*. Conversely, it usually pays less for covered services not furnished by a vision care *preferred provider*.

When an *employee* and his or her dependents enroll in this *plan*, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *preferred providers*.

What we pay is based on all of the terms of this *plan*. The *covered person* should read this material with care and have it available when seeking vision care. Read this *plan* carefully for specific benefit levels, frequencies, *copayments* and payment limits.

The *covered person* can call Davis Vision if he or she has any questions after reading this material.

Choice of Preferred Providers

When a person becomes enrolled in this *plan*, he or she will receive information about Davis Vision *preferred providers* in his or her area. A *covered person* may receive vision services from any current Davis Vision *preferred provider*.

When a *covered person* wants to receive services from a *preferred provider*, he or she must contact the *preferred provider* before receiving treatment. The *preferred provider* will contact Davis Vision to verify the *covered person's* eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a *preferred provider*.

This Plan's Vision Care Preferred Provider Organization (Cont.)

Non-Preferred Providers If a *covered person* receives services or supplies from a *non-preferred provider*, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

Claims for services or supplies from a *non-preferred provider* must be sent to:

Davis Vision - Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

CGP-3-DAVIS-05-PPOA

B505.0468

All Options

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the *covered person's* vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, *covered person* or patient may appeal denied authorizations or claim decisions. Should a *covered person* request a review of an authorization or claim decision, Davis Vision must notify the *covered person*, or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the *covered person* or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision's Grievance Resolution Process or as per plan contract. A *covered person* has the right to appeal through an external review organization at any time during the grievance process. A *covered person* has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the *covered person's* legal rights.

Grievance Process

Registering a Complaint or Grievance A *covered person* has the right to file a grievance or make an appeal to any claim decision at any time. The *covered person* has the right to designate a representative to file complaints and appeals on his or her behalf.

A *covered person* is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a *covered person* should the determination be made that vision care benefits are not available.

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:

1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

A grievance or complaint can arise from and includes but is not limited to the following:

1. benefit denials.
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract.
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services.
4. challenges with vision care services or products received.
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication

A *covered person* may file a verbal grievance by contacting Davis Vision. Registering a grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the grievance or appeal is received.

A *covered person* has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact their Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: **1 (800) 584-1487**.

Written Grievances

Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

**Davis Vision
159 Express Street
Plainview, New York 11803
Attention: Quality Assurance/Patient Advocate Department**

A *covered person* can register any concern or grievance by logging on to Davis' website: www.davisvision.com and entering the "Contact Davis Vision" area.

Appeal Level 1 Upon receipt of a concern or grievance by a Davis Vision associate, the *covered person* is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the *covered person* or his or her designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the *covered person* and may request additional information. Details of the complaint are documented in the *covered person's* file. The *covered person* is given the Associate's name, phone number, department and the estimated time needed to perform the research. The *covered person* is informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the *covered person* when further information is required and inform them of the status of the investigation or the need for more information.

CGP-3-DAVIS-05-APP-2

B505.0470

All Options

The determination will be communicated to the *covered person* within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the *covered person* within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.

Internal Grievance Procedure (Cont.)

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the *covered person* to Davis Vision within fifteen (15) business days of the date of notice of the decision.

Appeal Level 2 Should Davis Vision uphold a denial, as the result of a Level 1 review, the *covered person* has the right to request a Level 2 appeal.

A Level 2 appeal will not include associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the *covered person* to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The *covered person* requesting a Level 2 appeal must indicate the reason they believe the denial of coverage was incorrect. Davis Vision reserves the right to request further information from the *covered person* or provider.

Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 pre-service review. Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision Associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination the *covered person* will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

External Grievance Procedure

External Review A *covered person*, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A *covered person* who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

External Grievance Procedure (Cont.)

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

External Review Process A *covered person* has the right to an external review of a denial of coverage. A *covered person* has the right to an external review of a final adverse decision under the following circumstances:

- the *covered person* has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the *covered person* has been denied and any alternative service or treatment will not affect the *Covered person's* ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.
- the denied service, procedure or treatment is a covered benefit under the *Covered person's* policy.
- the *covered person* has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the *covered person* and the subsequent diagnostic findings could alter the *covered person's* treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.

CGP-3-DAVIS-05-APP-2

B505.0471

All Options

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. What we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

Covered charges are the *usual* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

CGP-3-DAVIS-05-HPW

B505.0472

All Options

Copays A *covered person* must pay a copay each time he or she receives a vision examination. A *covered person* must pay a copay each time he or she receives any vision materials covered by this *plan*.

CGP-3-DAVIS-05-COP

B505.0474

All Options

How We Cover Vision Examinations A *covered person* must pay a \$10.00 copay each time he or she receives a vision examination. If the vision examination is performed by a *preferred provider*, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a *non-preferred provider*, we pay benefits in excess of the copay up to \$46.00.

We pay benefits for one vision examination in any 12 month period.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;

- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

CGP-3-DAVIS-05-VE

B505.0478

All Options

How We Cover Vision Materials We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or *lenticular lenses*. We pay benefits for frames. We pay benefits for prescription contact lenses.

In any 12 month period, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any 24 month period, we pay benefits for one set of frames.

CGP-3-DAVIS-05-VM

B505.0806

All Options

How We Cover Standard Lenses A *covered person* must pay a \$25.00 copay each time he or she purchases *standard lenses*. If the lenses are received from a *preferred provider*, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a *non-preferred provider*, we pay benefits in excess of the copay up to:

- \$47.00 for single vision lenses;
- \$66.00 for bifocal lenses;
- \$85.00 for trifocal lenses; and
- \$125.00 for *lenticular lenses*.

We cover one pair of *standard lenses* in any 12 month period.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras;

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses (for children up to age 20 and monocular individuals and *Covered Persons* with prescriptions of greater than +/-6.00 diopters);
- glass-grey #3 prescription sunglasses.

The following cosmetic lens extras are not covered. But if a *covered person* purchases his or her lenses from a *preferred provider*, the price will be discounted as follows:

- standard progressive addition lenses - \$50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - \$90

- photochromatic lenses - single vision or multifocal - \$20
- scratch resistant coating - single vision or multifocal - \$20
- ultra violet coating - \$12
- blended invisible bifocal lenses - \$20
- intermediate Lenses - \$30
- plastic photosensitive lenses - \$65
- polarized lenses - \$75
- hi-Index lenses - \$55
- supershield (scratchguard) coating - \$20
- glare resistant treatment (multi layer hydrophobic) - \$35
- premium glare resistant treatment - \$48

CGP-3-DAVIS-05-SL

B505.0485

All Options

How We Cover Elective Contact Lenses

We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of *standard lenses* and frames.

If we cover charges for elective contact lenses, we will not cover charges for *standard lenses* and frames for at least 12 months.

A *covered person* must pay a \$25.00 copay each time he or she purchases elective contact lenses.

If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the copay up to a maximum of \$105.00.

If the contact lenses are purchased from a *preferred provider*, we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a \$25.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of \$135.00. The copay is waived.

We cover one pair of elective contact lenses in any 12 month period.

CGP-3-DAVIS-05-ECL

B505.0836

All Options

How We Cover Necessary Contact Lenses

We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of *keratoconus*; and

How This Plan Works (Cont.)

- the *covered person* complies with the following requirements regarding prior notification.

The *covered person* or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of *keratoconus* before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A *covered person* must pay a \$25.00 *copay* each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a *preferred provider*, we pay benefits in full for the lenses in excess of the *copay*. If the contact lenses are purchased from a *non-preferred provider*, we pay benefits in excess of the *copay* up to a maximum of \$210.00.

CGP-3-DAVIS-05-NCL-TX

B505.0511

All Options

How We Cover Frames

A *covered person* must pay a copay each time he or she purchases a set of frames.

If the frames are purchased from a *non-preferred provider*, we pay benefits in excess of a \$25.00 copay up to \$47.00.

If the frames are purchased from a *preferred provider*, we pay benefits in excess of the copay as follows:

- If a *preferred provider* offers Davis' Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a \$25.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a \$50.00 copay.
- We cover a non-Tower frame in excess of a \$25.00 copay up to the retail frame allowance of \$135.00.

We cover one set of frames in any 24 month period.

CGP-3-DAVIS-05-FRM

B505.0490

All Options

Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental training.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an *employer* as a condition of employment.
- We won't pay for *plano lenses* (lenses with less than a +/- .38 diopter power).
- We won't pay for two sets of glasses in lieu of bifocals.

Exclusions (Cont.)

- We won't pay for replacement of lenses and frames furnished under this *Plan* which are lost or broken, except at normal intervals when services are otherwise available.
- We won't pay for necessary contact lenses prescribed for a *covered person* affected with *keratoconus* for which prior notification was not sent to Davis Vision.
- We won't pay for lens cosmetic extras that are not specifically listed in this *Plan* as covered.

CGP-3-DAVIS-05-EXC

B505.0492

CERTIFICATE AMENDMENT

(To be attached to certificates issued to you)

The certificate is amended as follows:

This rider amends this plan's Life Insurance certificate as follows:

1. The Examination Period provision as shown below is hereby added to your certificate:

Examination Period A person age 65 or older insured under the policy has the right to return the policy or certificate, by mail or other delivery method, within 30 days after its receipt, and to have the full premium and any policy or membership fee paid refunded.

2. The Continuation of Coverage During a Labor Dispute provision as shown below is hereby added to your certificate:

**Continuation Of
Coverage During A
Labor Dispute**

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

If A Work Stoppage Occurs: A labor dispute may result in a work stoppage which causes an employee's group coverage to end. If this happens, an employee has the right to continue his health coverage for himself and his dependents during the work stoppage, for up to six months.

How To Continue Group Coverage: To continue his group coverage an employee must make timely payment of the total premium, including any portion of the premium the employer was paying before work stopped, to the Policyholder. If an employee fails to pay a premium on time, he waives his right to continue under this section.

The Responsibilities of the Policyholder: For an employee's group coverage to continue, the Policyholder must do the following:

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

If Policyholder, after timely receipt of the employee's premium, fails to pay us on behalf of such employee, thereby causing the employee's group coverage to end, then Policyholder will be liable for the employee's benefits, to the same extent as, and in place of, us.

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

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

When This Continuation Ends: An employee's continued group coverage ends on the first of the following:

- (a) the end of the six month continuation period;
- (b) the day on which the number of employees covered under this section is less than 75% of those insured under the group plan on the day work stopped;
- (c) the day the work stoppage ends;
- (d) when the employee enters full-time employment with another employer;
- (e) at the end of the period for which the last premium payment is made, if the employee stops paying premium;
- (f) the date the employee stops being eligible as defined in this plan, for reasons other than not meeting "actively at work" or "full-time" requirements; and
- (g) with respect to a dependent, the date such dependent stops being an eligible dependent as defined in the group plan.

3. The Incontestability provision is hereby replaced, as follows:

Incontestability The validity of the policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from its date of issue. No statements made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written statement signed by such person.

If a photographic identification is presented during the application or enrollment process, and if an imposter is substituted for an insured person in any part of the application or enrollment process, with or without the knowledge of such person, then no contract between Guardian and such person is formed, and any purported insurance contract is void from its inception.

Application or enrollment process means any or all of the steps required of an insured person in applying for a certificate under a group policy of life insurance, including, but not limited to, executing any part of the application or enrollment form, submitting to medical or physical examination or testing, or providing a sample or specimen of blood, urine, or other bodily substance

Imposter means a person other than the insured person who participates in any manner in the application or enrollment process for a certificate under a group life insurance policy and represents himself or herself to be the insured person or represents that a sample or specimen of blood, urine, or other bodily substance is that of the insured person.

A Policyholder insurance under this policy shall be incontestable after two years from the Policyholder policy date of coverage under this policy, except for nonpayment of premiums.

If this policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or insured person's signed application for up to two years from this policy's policy date.

4. The Contract provision is hereby replaced, as follows:

The Contract The entire contract between the Guardian and the policyholder consists of this policy, the policyholder's application, a copy of which is attached hereto or endorsed hereon, and the individual applications, if any, of the employees.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

Any amendments to this policy will be without prejudice to any claim arising prior to the date of the change.

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

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

This rider is 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

A handwritten signature in black ink, appearing to read "Michael Estep", written in a cursive style.

Michael Estep, Vice President

B531.0684

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and for plans issued before 07/01/2017, is effective on the first Policy Anniversary following 07/01/2017. For plans issued after 07/01/2017, the rider is effective on the Policy Date.

The provision, **Timely Access to Care** is added:

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of a *covered person's* condition consistent with good professional dental practice.

Guardian's *dental preferred provider organization (PPO)* has adequate capacity and availability of *preferred providers* to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of a *covered person's* condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if a *covered person* is requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating *dentist*, acting within the scope of the *dentist's* practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on a *covered person's* health.

When it is necessary for a *covered person's dentist* or a *covered person* to reschedule an appointment, the appointment will be promptly rescheduled by a *covered person's dentist* in a manner that is:

- Appropriate for a covered person's dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for a *covered person* at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Preferred providers are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how a *covered person* may obtain urgent or emergency care, including how to contact another *dentist* who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the *preferred provider* does not answer and a *covered person* has an emergency, a *covered person* may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any *dentist*.

Telephone triage or screening services are to be provided in a timely manner appropriate for a *covered person's* condition. During normal business hours the waiting time for a *covered person* to speak by telephone with a knowledgeable and competent customer service representative regarding a *covered person's* questions and concerns will not exceed 10 minutes.

If a *covered person* has any questions or want to request an interpreter, please call Our Customer Response Unit at 1-800-541-7846 or the toll-free number on the *covered person's* ID card.

The provision, **Continuity Of Care** is added:

Continuity Of Care

At a *covered person's* request, we can arrange for the completion of covered services by a terminated *dentist* for the duration of an acute condition. A terminated *dentist* means a *dentist* whose contract to provide services to *covered persons* is terminated or not renewed by us or one of our contracting dental groups. A terminated *dentist* is not a *dentist* who voluntarily leaves us or our contracting dental group. A *covered person* must be undergoing a course of treatment for an acute condition and the *covered person's* coverage under the Policy must continue during the completion of covered services.

Acute condition: This term means a dental condition that involves a sudden onset of symptoms due to a dental problem that requires prompt dental attention and that has a limited duration.

This Rider amends the Policy regarding the term "**spouse**" as follows:

Reference to the term "spouse" within the contract, means the person to whom you are legally married, or your registered domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in your state of residence or the state in which the marriage or your registered domestic partner, civil union partner or equivalent was recorded.

The **Eligible Dependents For Dependent Dental Benefits** provision is revised with the following:

Your *eligible dependents* are: (a) your spouse; and (b) your dependent children including:

- A newborn child, natural child, stepchild or a child placed with you for adoption or foster care who is under age 26.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage Past the Child Age Limit

A child who is incapable of self-support because of a physically or mentally disabling injury, illness or condition. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:

- The condition started before he or she reached the age limit; and
- The child remained continuously covered until he or she reached the age limit; and
- We will send notice to you at least 90 days prior to the limiting age and you must send us written proof that the child is dependent upon you for support and maintenance as is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. You have 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the child's eligibility is made. We can ask for periodic proof that the child's condition continues, but we cannot ask for this proof more than once a year after the two-year period following the child's attainment of the limiting age.

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

B531.0825

CERTIFICATE AMENDMENT

The certificate is amended as follows:

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

- (a) your dependent child is a child under age 26;
- (b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);
- (c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and
- (d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

COORDINATION OF BENEFITS

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

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

Definitions

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

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

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

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

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

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

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

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

Plan This term means any of the following that provides benefits or services for health care or treatment: (1) group, blanket or franchise insurance coverage; (2) service plan contracts, group practice, individual practice and other prepayment coverage; (3) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and (4) governmental benefits, except Medicare, as permitted by law.

This term does not include: (a) individual or family insurance; (b) individual or family subscriber contracts; (c) school-type blanket accident and sickness insurance; (d) blanket accident insurance that is excess to other coverage; (e) medical benefit payments in traditional automobile contracts; or (f) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

CGP-3-R-COB-05

B555.0293

Option E

Order Of Benefit Determination

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

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

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

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

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

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

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

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

Order Of Benefit Determination (Cont.)

- (2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

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

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

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

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

CGP-3-R-COB-05

B555.0295

Option E

Effect On The Benefits Of This Plan

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

CGP-3-R-COB-05

B555.0296

CERTIFICATE AMENDMENT

Notwithstanding any provision in the Plan to the contrary, it is hereby agreed that the Group Plan is amended September 1, 2007 so that,

- (A) A Covered Person may select any holder of a license issued under Section 2135, 1000, 1634 or 2948 of the California Business and Professions Code, to perform any Covered service such holder is expressly authorized by law to perform.
- (B) A Covered Person may select a clinical social worker who is the holder of a license issued under Section 9040 of the California Business and Professions Code, to perform any covered service which such social worker is expressly authorized by law to perform, provided such Covered Person is referred to such social worker by a licensed physician or surgeon.
- (C) A Covered Person may select an occupational therapist, regulated under Section 2570 of the California Business and Professions Code to perform any covered service which such Occupational Therapist is expressly authorized by law to perform, provided such Covered Person is referred to such occupational therapist by a licensed physician or surgeon.
- (D) A Covered Person may select a speech pathologist or audiologist, licensed under section 2530 of the California Business and Professions Code, to perform any covered service which such speech pathologist or audiologist is expressly authorized by law to perform, provided such Covered Person is referred to such speech pathologist or audiologist by a licensed physician or surgeon.
- (E) A Covered Person may select a marriage, family, and child counselor, licensed under Section 17805 of the California Business and Professions Code, to perform any covered service which such family, marriage, and child counselor is expressly authorized by law to perform, provided Covered Person is referred to such family, marriage, and child counselor by a licensed physician or surgeon.

This Rider shall form a part of the Policy, Except as stated in this Rider, nothing contained herein shall be held to alter or affect any of the provisions of the policy, including any prior Riders, Amendments, or Endorsements.

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118

Option E

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

CGP-3-GLOSS-90

B750.0663

Option E

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

CGP-3-GLOSS-90

B750.0664

Option E

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

CGP-3-GLOSS-90

B750.0665

Option E

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

CGP-3-GLOSS-90

B750.0666

All Options

Blended Lenses means bifocals which do not have a visible dividing line.

CGP-3-GLOSS-90

B750.0781

All Options

Coated Lenses means substance added to a finished lens on one or both surfaces.

CGP-3-GLOSS-90

B750.0782

All Options

Copay means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* before any benefits are paid by this *plan*.

CGP-3-GLOSS-90

B750.0783

Option E

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

CGP-3-GLOSS-90

B750.0667

Option E

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

CGP-3-GLOSS-90

B750.0668

Option E

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

CGP-3-GLOSS-90

B750.0669

All Options

Covered Person with respect to vision care insurance means an *employee* or *eligible dependent* who meets this *plan's* eligibility criteria and who is covered under this *plan*.

CGP-3-GLOSS-90

B750.0784

All Options

Customary means, when referring to a covered charge, that the charge for the covered vision condition is not more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-GLOSS-90

B750.0785

Option E

Dental Prosthesis means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

CGP-3-GLOSS-90

B750.0670

Option E

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

CGP-3-GLOSS-90

B750.0671

All Options

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

CGP-3-GLOSS-90

B900.0003

All Options

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

CGP-3-GLOSS-90

B750.0015

Option E

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this *plan*.

CGP-3-GLOSS-90

B750.0672

All Options

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

CGP-3-GLOSS-90

B750.0006

All Options

Employer means HILTON WATERFRONT BEACH RESORT .

CGP-3-GLOSS-90

B900.0051

All Options

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

CGP-3-GLOSS-90

B900.0004

All Options

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

CGP-3-GLOSS-90

B750.0229

All Options

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

CGP-3-GLOSS-90

B900.0006

Option E

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

CGP-3-GLOSS-90

B750.0673

All Options

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

CGP-3-GLOSS-90

B750.0786

All Options

Lenticular Lenses means high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

CGP-3-GLOSS-90

B750.0787

All Options

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

CGP-3-GLOSS-90

B900.0008

Option E

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider*.

CGP-3-GLOSS-90

B750.0674

All Options

Non-Preferred Provider with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the *covered persons* of the *plan*.

CGP-3-GLOSS-90

B750.0788

Option E

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances*. it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

CGP-3-GLOSS-90

B750.0675

All Options

Orthoptics means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

CGP-3-GLOSS-90

B750.0789

All Options

Oversize Lenses means larger than a standard lens blank to accommodate prescriptions.

CGP-3-GLOSS-90

B750.0790

Option E

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

CGP-3-GLOSS-90

B750.0676

Option E

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

CGP-3-GLOSS-90

B750.0677

All Options

Photochromic Lenses means lenses which change color with the intensity of sunlight.

CGP-3-GLOSS-90

B750.0791

Option E

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

CGP-3-GLOSS-90

B750.0679

Option E

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

CGP-3-GLOSS-90

B750.0678

Option F

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

CGP-3-GLOSS-90

B900.0039

All Options

Plan means the Davis Vision plan of vision care services described herein.

CGP-3-GLOSS-90

B750.0792

All Options

Plano Lenses means lenses which have no refractive power (lenses with less than a +/- .38 diopter power).

CGP-3-GLOSS-90

B750.0793

Option E

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

CGP-3-GLOSS-90

B750.0680

All Options

Preferred Provider with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan*.

CGP-3-GLOSS-90

B750.0794

Option E

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

CGP-3-GLOSS-90

B750.0681

Option E

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

CGP-3-GLOSS-90

B750.0682

All Options

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90

B900.0010

All Options

Standard Lenses means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

CGP-3-GLOSS-90

B750.0795

All Options

Tinted Lenses means lenses which have an additional substance added to produce constant tint.

CGP-3-GLOSS-90

B750.0796

All Options

Usual means when referring to a covered charge that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

CGP-3-GLOSS-90

B750.0797

Option E

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

CGP-3-GLOSS-90

B750.0683

All Options

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

STATEMENT OF ERISA RIGHTS

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions By Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement Of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Statement of Erisa Rights (Cont.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.

B800.0094

All Options

The Guardian's Responsibilities

B800.0048

Option E

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

B800.0053

All Options

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

B800.0055

All Options

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

B800.0049

Group Health Benefits Claims Procedure

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

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

Pre-Service Claims. Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Post-Service Claims. Guardian will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Group Health Benefits Claims Procedure (Cont.)

Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided(a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;

Group Health Benefits Claims Procedure (Cont.)

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

B800.0076

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

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

B800.0007

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with the authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has the authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

**Adverse Benefit
Determination of
Life Insurance
Claims**

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

B752.0173

All Options

**Appeals of Adverse
Determinations of
Life Insurance
Claims**

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B752.0067

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B752.0068

SECTION II: Managed Dental Care of California Dental Plan

This part of your booklet is your Managed Dental Care of California dental care plan. This part does not include any insurance that is being underwritten by Guardian.

None of the following provisions apply to any of your other insurance coverages.

B850.1557

This Booklet Includes All Managed Dental Care Benefits For Which You Are Eligible.

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

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

"Please Read This Document Carefully".

B850.1499

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care of California

21820 Burbank Boulevard, Suite 200 or
Woodland Hills, California 91367
1-800-273-3330

We, MDC, certify that the *employee* named below is entitled to the benefits provided by MDC described in this form, provided the eligibility and effective date requirements of the *plan* are satisfied.

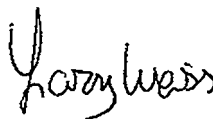
Group Policy No.	Form No.	Effective Date
Issued To		

"This Evidence of Coverage and Disclosure Form constitutes only a summary of the Health *plan*. The dental care *plan* contract must be consulted to determine the exact terms and conditions of coverage." A specimen copy of the *plan* contract will be furnished upon request. The Health Plan Benefits and Coverage Matrix is attached. The applicant has a right to view the Evidence of Coverage prior to enrollment. The Evidence of Coverage discloses the terms and conditions of coverage. What we cover is based on all the terms of this *plan*. Read this booklet carefully and completely for specific benefit levels, payment rates, payment limits, and copayments. Individuals with special health care needs should read carefully those sections that apply to them. You may call the MDC Member Service Department at 1-800-273-3330 if you have any questions after reading this booklet, or contact the

plan at the plan's principal address listed above.



Eric Krohne, President



Larry Weiss, Assistant Vice President
and Controller

CGP-3-MDC-CA-1-08

B850.1509

Option F

GENERAL PROVISIONS

Public Policy Committee MDC maintains a Public Policy Committee composed of at least 3 Members, one Participating Dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee. MDC communicates material changes affecting public policy to members in periodic newsletters.

Confidentiality **A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.**

You may contact our Member Services Department by telephone, 800-273-3330, or by mail to P.O. Box 4391, Woodland Hills, CA 91367 to request a copy of the plan's Confidentiality Statement. The Confidentiality Statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

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Option F

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures You and your Dependents may enroll for dental coverage by: (a) filling out and signing the appropriate enrollment form and any additional material required by your Employer; and (b) returning the enrollment material to your Employer. After your enrollment material has been received by MDC, You or your Dependents need only contact the selected and assigned Primary Care Dentist's office to obtain services.

MDC will issue You and each of your Dependents, either directly or through your Employer's representative, an MDC ID card. The ID card will show the Member's name and the name, address and telephone number of the selected and assigned Primary Care Dentist.

Member Eligibility and Termination Provisions (Cont.)

In the event dental coverage is provided for a dependent pursuant to a court or administrative order, a non-covered custodial parent (or guardian) will be provided a copy of the dependent's Evidence of Coverage and Disclosure Form and an ID card if requested by telephone or in writing. Upon receipt of appropriate notification, the Plan will notify the non-covered custodial parent or guardian if the dependent's coverage is altered or terminated.

In the event an eligible employee is required by a court or administrative order to provide dental coverage for a dependent, the dependent, who is otherwise eligible, will be permitted to enroll without regard to enrollment period restrictions.

If the enrolled employee fails to obtain coverage for the dependent, the dependent may be enrolled upon presentation of the court order, or request of the District Attorney, the other parent or guardian, or the Medi-Cal program.

The Plan shall not disenroll or eliminate coverage of the Dependent unless either of the following applies:

1. the Employer terminates coverage for all Employees.
2. the Plan is provided with satisfactory written evidence that either of the following apply:
 - (a) court order or administrative order is no longer in effect or is terminated pursuant to Section 3770.
 - (b) the dependent is or will be enrolled in comparable dental coverage that will take effect not later than the effective date of the dependent's disenrollment.

Eligible Dependents Eligible Dependents are (1) your spouse, (2) your or your spouse's Dependent Child who is less than 26 years of age. The term Dependent Child as used in this Plan will include any stepchild, newborn child between birth and age 36 months, legally adopted child, child for whom you are court appointed legal guardian, or proposed adoptive child, during any waiting period prior to the formal adoption if the child is part of your household and is primarily dependent on you for support and maintenance. The term also includes any child for whom a court-ordered decree requires you to provide dependent coverage; (3) a mentally retarded or physically handicapped Dependent Child who has reached the upper age limit of a Dependent Child, is not capable of self-sustaining work, and depends primarily on you for support and maintenance; (4) an Employee's domestic partner, who may be treated as a spouse under this Plan, subject to the conditions below:

An employee's domestic partner will be eligible for dental coverage under this Plan. "Domestic Partner" means an adult who has chosen to share his or her life with the employee in an intimate and committed relationship of mutual caring. Coverage will be provided subject to all of 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;

Member Eligibility and Termination Provisions (Cont.)

- be unmarried, and not a member of another domestic partnership;
- have a common residence;
- agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership;
- not be related by blood in a way that would prevent them from being married to each other in the state of California;
- be capable of consenting to the domestic partnership;
- file a Declaration of Domestic Partnership with the Secretary of State of the state of California; and
- not have previously filed a Declaration of Domestic Partnership that has not been terminated; and
- be (a) members of the same sex, or (b) opposite sexes and one or both are eligible for Social Security benefits and over the age of 62.

Before coverage may become effective, the employee must submit to us, a copy of a valid Declaration of Domestic Partnership attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this Plan on the same basis as if the children were the employee's dependent children.

Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as described above. Upon termination of a domestic partnership, a "Notice of Termination of Domestic Partnership" must be completed and filed with the Secretary of State and the employer. A new Declaration of Domestic Partnership may not be filed with the Secretary of State until at least 6 months after the filing of a Notice of Termination of Domestic Partnership.

The domestic partner and his or her children will not be eligible for continuation of dental coverage as explained under the "Federal Continuation Rights" section of this Plan.

Eligibility The determination of who is eligible to participate and who is actually participating in the plan shall be determined by your Employer and the group contract.

Any disputes or inquiries regarding eligibility, renewal, reinstatement and the like should be directed to your Employer or MDC as appropriate. MDC will not discriminate against any member based upon age, race, religion, national origin, sex, or sexual orientation.

Changes in Member Status If a Member is terminated or is no longer employed: (a) he or she will continue to be eligible to receive services; and (b) MDC will be entitled to its monthly premium for the Member until such time that: (i) MDC is notified in writing of the Member's termination; and (ii) the Member is removed from the eligibility listing specified above.

Member Eligibility and Termination Provisions (Cont.)

SHOULD MDC BE NOTIFIED OF A MEMBER'S TERMINATION AFTER THE 20TH DAY OF THE MONTH FOLLOWING THE MONTH OF TERMINATION, MDC WILL RETAIN OR MUST BE PAID THE PREMIUM FOR THE MONTH IN WHICH THE MEMBER'S TERMINATION WAS REPORTED.

When Your Coverage Starts Your coverage starts on the date shown on the face page of this *plan* if you are enrolled when the *plan* starts. If *you* are not enrolled on this date, your coverage will start on: (a) the first day of the month following the date enrollment materials are received by MDC; or (b) the first day of the month after the end of any waiting period your *employer* may require.

When Your Dependent Coverage Starts Except as stated below, your *dependents* will be eligible for coverage on the later of (a) the day *you* are eligible for coverage; or (b) the first day of the month following the date on which *you* acquire such *dependent*. If your *dependent* is a newborn child, his or her coverage begins on the date of birth. If your *dependent* is: (a) an adopted child; (b) a stepchild; or (c) a foster child, coverage begins on the date of placement in your home. If a newborn child, adopted child or foster child becomes covered under this *plan*, *you* must complete enrollment materials for such child within 30 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 30 days.

Premium Your Employer is responsible for paying MDC the monthly premium for your coverage. This amount, along with any portion you must pay, is shown in your enrollment kit.

Benefits, Limitations and Exclusions A complete list of covered services, limitations and exclusions are included in the benefits section of this booklet. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a patient charge. Services specifically excluded from this coverage are listed in the section titled Exclusions and Limitations. Please read this section carefully. Dental services performed by a non-participating Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Care.

Renewal MDC has contracted with your employer to provide services for a specific time period as specified in the group contract. You are covered under the plan for that period. Upon renewal of the group contract, it is possible the plan may be amended. Your employer will notify you of any benefit changes made at renewal.

Termination of Benefits

Subject to any continuation of coverage which may be available to you or your Dependents, coverage under this Plan ends when your Employer's coverage terminates. Your and your Dependents' coverage ends on the first to occur of:

Member Eligibility Reasons (1) the end of the month in which a Member is no longer eligible for coverage under this Plan.

Member Eligibility and Termination Provisions (Cont.)

- (2) the end of the month in which your Dependent is no longer a Dependent as defined in this Plan.
- (3) the date on which you or your Dependent no longer reside or work in the Service Area.

A Member may be terminated at the end of the month following a period of at least fifteen (15) days from the date of notification of termination mailed by the Plan to the Member's address of record with the Plan. See Individual Continuation of Benefits, below.

Member Cancellation Reasons

- (4) Immediately, as of date of notification, if a Member has knowingly given false information in writing on an enrollment form or has misused his or her ID card or other documents provided to obtain benefits available under this Plan.

Member will be terminated immediately upon notification of termination mailed by the Plan to the Member's address of record with the Plan.

- (5) If the Member threatens the safety of Plan Employees, Dentists, Members, or other patients, or the Member's repeated behavior has substantially impaired the Plan's ability to furnish or arrange services for the Member or other Members, or substantially impaired a dentist's ability to provide services to other patients. Member will be terminated immediately upon notification of termination mailed by the Plan to the Member's address of record with the Plan.

A Member may be terminated at the end of the month following a period of at least fifteen (15) days from the date of notification of termination mailed by the Plan to the Member's address of record with the Plan.

MDC will: (a) make a reasonable effort to resolve the problem presented by the Member, including the use or attempted use of Member grievance procedures; (b) ascertain, to the extent possible, that the Member's behavior is not related to the use of medical services or mental illness; and (c) document the problems, efforts and medical conditions on which the problem is based.

Pursuant to Section 1365(b) of the Knox Keene Act, any Member who alleges his or her enrollment has been cancelled or not renewed because of his or her health status or requirement for services may request review by the California Department of Managed Health Care.

Group Cancellation Reasons

- (6) The end of the month during which your Employer receives written notice from you requesting termination of coverage for you or your Dependents, or on such later date as you may request by the notice.
- (7) A Member may also be terminated for Employer's nonpayment of premiums.

Member Eligibility and Termination Provisions (Cont.)

Nonpayment of Premiums Member's coverage will be terminated for nonpayment of premiums. This will not occur until at least 15 days have passed following Plan's mailing of a notice of cancellation to Employer. This is not applicable to a loss of eligibility for Medi-Cal Benefits. The effect of nonpayment of premium will result in the Member being financially responsible for the cost of services rendered after termination of benefits. However, ongoing services initiated prior to Member's termination of coverage, including inlays, onlays, crowns, fixed bridges, orthodontic or root canal treatment shall be completed by the member's PCD at the applicable Copayment.

Notice of Cancellation MDC will notify Employer in writing of the cancellation of the Group Contract. The group may be terminated at the end of the month following a period of at least (15) days from the date of notification of termination mailed to the Employer's address of record with the Plan. A notice of termination will be sent to the Employer following the (15) day notification period. Employer is required to mail Employees a legible, true copy of any notice of cancellation of the Group Contract which may be received from the Plan and must provide MDC with proof of the mailing and date of mailing, within 72 hours of receipt of Notice of Cancellation. The notice will include information regarding the conversion rights of Members covered under the Plan Contract. Plan will accept a copy of the notice as proof.

If the Group does not avoid cancellation of the Group Contract within the required 15 days, or if the Group Contract is cancelled for nonpayment during a contract year, the Group may need to reapply for coverage with a new application, for which the Plan may impose different premiums. The effect of nonpayment of premium will result in the Member being financially responsible for the cost of services rendered after termination of benefits. However, ongoing services initiated prior to Member's termination of coverage, including inlays, onlays, crowns, fixed bridges, dentures, orthodontic or root canal treatment shall be completed by the Member's PCD at the applicable Copayment.

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YOUR CONTINUATION RIGHTS

You and your dependents may be eligible to retain coverage under this plan during any Continuation of Coverage period or election period, necessary for your employer's compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for members, provided the employer continues to certify the eligibility of the member and the monthly premiums for COBRA coverage for the member continue to be paid by or through your employer pursuant to this plan.

An Important Notice About Continuation Rights

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

Federal Continuation Rights

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

This section applies to dental benefits only. In this section, these coverages are referred to as "group dental benefits."

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 dental benefits under this plan as: (a) an active, covered *employee*; (b) the spouse of an active, covered *employee*; or (c) the *dependent* of an active, covered *employee*. Any person who becomes covered under this *plan* during a continuation provided by this section is not a qualified continuee.

If Your Group Dental Benefits End If your group dental benefits end due to termination of employment or reduction of work hours, *you* may elect to continue such benefits for up to 18 months if: (a) *you* were not terminated due to gross misconduct; (b) *you* are not covered for benefits from any other group plan at the time your group dental benefits under this plan would otherwise end; and (c) *you* are not entitled to Medicare.

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

Federal Continuation Rights (Cont.)

Extra Continuation For Disabled Qualified Continuees	If a qualified continuee is determined to be disabled under Title XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to his or her termination of employment or reduction of work hours, he or she 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, the qualified continuee must give your <i>employer</i> written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; and (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 <i>employer</i> within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends." This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends." An additional 50% of the total premium charge also may be required from the qualified continuee by your <i>employer</i> during this extra 11 month continuation period.
If You Die While Insured	If <i>you</i> die while insured, any qualified continuee whose group dental 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 dental 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 loses Eligibility	If a <i>dependent's</i> group dental benefits end due to his or her loss of dependent eligibility as defined in this <i>plan</i>, other than your coverage ending, he or she may elect to continue such benefits. But, such <i>dependent</i> must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends."
Concurrent Continuations	If a <i>dependent</i> elects to continue his or her group dental benefits due to: (a) your termination of employment; or (b) your reduction of work hours, the <i>dependent</i> may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (a) the <i>dependent</i> becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (b) <i>you</i> 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.
The Qualified Continuee's Responsibilities	A person eligible for continuation under this section must notify your <i>employer</i>, in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of dependent eligibility, as defined in this <i>plan</i>, of a <i>dependent</i>.

Federal Continuation Rights (Cont.)

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

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 dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer*, in writing, of your legal divorce or legal separation from your spouse, or the loss of dependent eligibility of a *dependent*.

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

Election of Continuation To continue his or her group dental benefits, the qualified continuee must give your *employer* written notice that he or she elects to continue. This must be done within 60 days of the date a qualified continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's premium in a timely manner.

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

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group *plan* on a regular basis. It includes any amount that would have been paid by your *employer*. Except as explained in the "Extra Continuation for Disabled Qualified Continuees," your *employer* may also require an additional charge of 2% of the total premium charge.

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

Grace in Payment of Premiums A qualified continuee's premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

Federal Continuation Rights (Cont.)

- When Continuation Ends** A qualified continuee's continued group dental benefits end on the first to occur of:
- (a) 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 dental benefits would otherwise end;
 - (b) with respect to a disabled qualified continuee who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date the group dental benefits would otherwise end; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
 - (c) with respect to continuation upon your death, your legal divorce or legal separation, or the end of a *dependent's* eligibility, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
 - (d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
 - (e) the date the *plan* ends;
 - (f) the end of the period for which the last premium payment is made;
 - (g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or
 - (h) the date he or she becomes entitled to Medicare.

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Option F

DENTAL EXPENSE COVERAGE

This *plan* will cover many of the dental expenses incurred by *you* and those of your *dependents* who are covered for dental benefits under this *plan*. MDC decides: (a) the requirements for benefits to be paid; and (b) what benefits are to be paid by this *plan*. *We* also interpret how this *plan* is to be administered. What *we* cover and the terms of coverage are explained below. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

MANAGED DENTALGUARD

MANAGED DENTAL CARE'S DENTAL COVERAGE PROGRAM

Managed DentalGuard This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires *members* to seek dental care from *participating dentists* that belong to the Managed DentalGuard network (MDG network).

The MDG network is made up of *participating dentists* in a *member's* Service Area. A " *participating dentist*" is a *dentist* that has a Managed DentalGuard agreement in force with MDC.

When a *member* enrolls in this *plan*, he or she will get information about MDC's current *participating general dentists*. Each *member* must select from this list of *participating general dentists* a *primary care dentist* (PCD) who will be responsible for coordinating all of the *member's* dental care. After enrollment, a *member* will receive a MDC ID card. A *member* must present this ID card when he or she goes to his or her PCD.

All dental services covered by this *plan* must be coordinated by the PCD whom *the member* selects and is assigned to upon enrolling in this *plan*. What we cover is based on all the terms of this *plan*. Read this *plan* carefully for specific benefit levels, exclusions and limitations and *patient charges*.

You can call the MDC Member Services Department if you have any questions after reading this booklet.

MDC has a written plan describing how this *plan* facilitates the continuity of care for new *members* receiving services from a *non-participating dentist* during a current episode of care for an acute condition. A *member* may request a copy of MDC's written plan which includes information on how he or she may request a review under this *plan*.

Choice of Dentists A Member may select any available *participating general dentist* as his or her PCD. A request to change a PCD must be made to MDC at 1-800-273-3330. Any such change will be effective the first day of the month following approval. MDC may require up to 30 days to process and approve any such request. All fees and *patient charges* due to the *member's* current PCD must be paid in full prior to such a transfer.

MDC compensates its *participating general dentists* through a capitation agreement by which they are paid a fixed amount of money each month, based upon the number of members that select them as their PCD.

MDC may also make supplemental payments on a limited number of specific procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from MDC. The *dentists* also receive compensation from plan members who may pay an office visit charge for each office visit and a defined *patient charge* for specific dental services. The schedule of *patient charges* is shown in the Covered Dental Services and Patient Charge section of this booklet.

If a *member* wishes to know more about these issues, the *member* may request additional information from the health care service plan, the *member's dentist* or the *dentist's* medical group or independent practice association regarding this information.

Managed Dental Care's Dental Coverage Program (Cont.)

You may wish to consult another *dentist* for a second opinion regarding services recommended or performed by your PCD or a *participating specialist* through an authorized referral. To have a second opinion consultation covered by MDC, you must call or write Member Services for prior authorization. MDC will only cover a second opinion consultation when the recommended services are otherwise covered under the *plan*.

A Member Services Representative will help you identify a *participating dentist* to perform the second opinion consultation. You may request a second opinion with a non-participating general *dentist* or specialist *dentist*. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist.

You may appeal a denial for a second opinion to:

Managed Dental Care of California
Grievance Committee
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

The appeal will be reviewed through the *plan's* grievance process on the basis of the necessity of the treatment and/or specialty procedure being recommended. Appeals are reviewed on the basis of all available dental records and the input of the referring dentist or specialist. All appeals for the necessity of a second opinion are reviewed by a *dentist* having appropriate clinical background, as determined by MDC's Dental Director.

Right to Reassign Member: MDC reserves the right to reassign you to a different Participating Dentist if: (a) the Dentist you have chosen is no longer a Participating Dentist in the MDG network; or (b) MDC takes an administrative action which impacts a Dentist's participation in the network. If this becomes necessary, you will have the opportunity to choose another Participating Dentist. If a Member has a dental service in progress at the time of the reassignment, MDC will, at its option and subject to applicable law, either: (a) arrange for completion of the services by the original Dentist; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service.

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Option F

Additional Information

In the event that MDC fails to pay your PCD, you shall not be liable to the participating general dentist for any sums owed by the *plan*. In the event MDC fails to pay a Non-Participating Dentist, you may be liable to the Non-Participating Dentist for the cost of services rendered.

Additional Information (Cont.)

Relationship Between You and Participating Dentists and Institutions: You understand that: (a) the operation and maintenance of the participating dental offices, facilities and equipment; and (b) the rendition of all dental services will be solely and exclusively under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment

MDC will undertake to see that the services provided to Members by Participating Dentists will be performed in accordance with professional standards prevailing in the county in which each Participating Dentist practices.

Specialty Referrals A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Participating Specialist. MDC will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty services are provided in accordance with the specialty referral process described below.

MDC compensates its Participating Specialists the difference between their contracted fee and the Patient Charge shown in the Covered Dental Services and Patient Charges section. This is the only form of compensation that Participating Specialists receive from MDC.

ALL SPECIALTY REFERRAL SERVICES MUST BE (A) PRE-AUTHORIZED BY MDC; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY MDC IS RESPONSIBLE FOR ALL CHARGES INCURRED.

EMERGENCY REFERRALS AUTHORIZED BY TELEPHONE MUST FOLLOW REFERRAL GUIDELINES TO BE COVERED UNDER THE PLAN OR RETROSPECTIVELY IT MAY BE DETERMINED THAT SERVICES RENDERED MAY BE THE RESPONSIBILITY OF THE REFERRING DENTIST AND/OR YOU. YOU ARE NOT HELD RESPONSIBLE IF THE REFERRING DENTIST DOES NOT FOLLOW PLAN GUIDELINES.

Utilization Review

In order for specialty services to be covered by this *plan*, the specialty referral process stated below must be followed:

1. A member's PCD must coordinate all dental care.
2. When the care of a *participating specialist* is required, the PCD must contact MDC and request authorization.
3. If the PCD's request for specialist referral is approved, MDC will notify *you*. He or she will be instructed to contact the *participating specialist* to schedule an appointment.

4. If the *PCD's* request for specialist referral is denied, the *PCD* and the *member* will be notified of the reason for the denial. If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply, the *PCD* may be asked to perform the service directly, or to provide additional information.
5. If a request for specialist referral is denied and the *member* wishes to submit additional information or documentation to be considered in the evaluation of the request, he or she may submit an appeal of the determination. The appeal of a denied request for authorization will follow the grievance process.
6. A *member* who receives authorized specialty services must pay for all applicable *patient charges* associated with the services provided.

When specialty dental care is authorized by MDC, a *member* will be referred to a *participating specialist* for treatment. The MDG network includes *participating specialists* in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) pediatric dentistry; and (e) orthodontics, located in the Member's Service Area. If there is no *participating specialist* in the *member's service area*, or if the specialist is not readily available and accessible as defined by MDC's Access Standards (Member Services may be contacted at 1-800-273-3330 for Plan Access and Availability Standards), MDC will refer *you* to a non-participating specialist of our choice. For those services approved in writing with a non-participating specialist, *you* will only be responsible for the applicable *patient charge* that would apply if the services were rendered by a contracted specialist. If *you* receive a bill from a non-participating specialist for charges other than the applicable *patient charge*, *you* will forward the bill to the *plan* for appropriate follow up. The bill should be sent to the attention of the Specialty Referral Department, P.O. Box 4391, Woodland Hills CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills CA 91367. In no event will MDC pay for dental care provided to a *member* by a specialist not pre-authorized by MDC to provide such services.

7. A *member*, member's designee and/or *dentist* whose *specialty referral* is denied as the service is not consistent with our clinical referral guidelines or is not necessary will receive written notification with a clear, concise explanation of the reasons for MDC's decision, a description of the screening criteria used, and the clinical reasons for the decision. The notification shall also include information as to how the *member* or member's designee may file an appeal or a grievance.
8. A *member*, member's designee and/or members of the public may request a copy of MDC's Specialty Referral Guidelines and/or Utilization Review and Utilization Review Appeals Processes. These are MDC's written policies and procedures that have established the processes by which the *plan* prospectively, retrospectively or concurrently reviews and approves, modifies, delays, denies, in whole or in part on medical necessity requests by dentists for plan enrollees. A copy may be obtained by contacting the Member Services Department by telephone at 800-273-3330 or by mail at P.O. Box 4391, Woodland Hills CA 91367.

Facilities

MDC's *PCD* offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if you cannot keep your scheduled appointment, you must notify your *PCD* at least 24 hours in advance or *you* will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet.

GCP-3-MDC10-B

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Option F

Emergency Dental Services

The MDG network also provides for *emergency dental services* 24 hours a day, 7 days a week, to all *members*. a *member* should contact his or her selected *PCD*, who will arrange for such care. If a *member* is not able to reach his or her *PCD* in an emergency during normal business hours, he or she must call MDC's Member Services Department for instructions. If a *member* is not able to reach his or her *PCD* in an emergency after normal business hours, the *member* may seek *emergency dental services* from any *dentist*. MDC will reimburse the *member* for the cost of the *emergency dental services*, less any *patient charge* which may apply.

Out-of-Area Emergency Dental Services

If a *member* is more than 50 miles from his or her *PCD's* office, and *emergency dental services* are required, he or she should seek care from a *dentist*. then he or she must file a claim within 30 days. He or she must present an acceptable detailed statement from the treating *dentist*. the statement must list all services provided. MDC will reimburse the *member* within 30 days for any covered *emergency dental services* up to \$50.00 per incident.

Continuity of Care - Terminated Dentist

Member may request for the continuation of covered services to be rendered by a terminated *participating dentist* when *member* is undergoing treatment from a terminated dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current members or 180 days from the effective date for newly covered members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Participating Dentist's Agreement or 12 months from the effective date of coverage for newly covered members. This provision does not apply to *participating dentists* who voluntarily leave the *plan*. *Member* must make the request in writing and send to:

Continuity of Care - Terminated Dentist (Cont.)

Managed Dental Care of California
Quality Management Department
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

Or contact MDC's Member Services Department at 1-800-273-3330 during normal business hours. The terminating *dentist* must accept the contracted rate for that member's treatment and agree not to seek payment from the *member* for any amounts for which the *member* would not be responsible if the *dentist* were still in the network. The approval of the request to continue member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating *dentist* or *member* wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

Continuity of Care - Non-Participating Dentist

Member, including a newly covered member, may request for the continuation of covered services to be rendered by the *non-participating dentist* when *member* is undergoing treatment from the *non-participating dentist* for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Participating Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members. Member must make the request in writing and send to:

Managed Dental Care of California
Quality Management Department
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

Or contact MDC's Member Services Department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the *member's* dental records from the *member's dentist* in order to evaluate the request. The Dental Director (or his/her designee) will determine if the *member* is eligible for continuation of care under this policy and the California Knox-Keene Act. The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by *plan*; and
3. The potential clinical effect that a change of dentist would have on the Member's treatment.

Continuity of Care - Arrangements with Dentists

MDC requires the terminated or non-participating dentist to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted dentists, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements. MDC is not required to continue the services a *dentist* is providing to a *member* if the *dentist* does not agree to comply or does not comply with these contractual terms and conditions.

Unless MDC and *dentist* agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by MDC for currently contracted dentists providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the non-participating dentist. MDC is not required to continue the services a dentist is providing to a Member if the dentist does not accept the payment rates provided for in this paragraph.

The amount of, and the requirement for payment of copayments during the period of completion of covered services with a terminated dentist or a non-participating dentist are the same as would be paid by the *member* if receiving care from a dentist currently contracted with MDC.

GCP-3-MDCEM

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Option F

MANAGED DENTAL CARE GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison or Designee ("QCL") who processes all grievances. The QCL may be contacted at 800-273-3330 between the hours of 8:00 a.m. and 5:00 p.m. Pacific Time or by mail to P.O. Box 4391, Woodland Hills, CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills, CA 91367. Grievances may also be submitted on the Plan's website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

Administrative Services financial, accounting, procedural matters, coverage information such as effective dates, explanations of Contract and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.

Health Services quality of care, access, availability, standards of care, appeal of denied second opinion requests, Utilization Review Appeals, professional and ethical considerations.

Managed Dental Care Grievance Process (Cont.)

A Grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding the plan's operation, including but not limited to, plan administration, denial of access to a specialty referral as services are covered at the general dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for lack of medical necessity will be handled by the grievance process. The Plan will not treat inquiries as grievances, but if the Plan cannot distinguish between an inquiry and a grievance, they shall be considered grievances.

A grievance and a complaint are one and the same.

Coverage dispute means that the Member is not provided a covered service as a Plan benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the Member Services Representative documents the call and works with the Member to resolve the issue. If the issue is an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the Member Services Department. All other issues that are grievances will be documented on a Grievance Form by the Member Services Representative on behalf of the Member and the Grievance Form will be forwarded to the Quality of Care Liaison or Designee ("QCL"). The Member may be sent a Grievance Form (Exhibit 2) to complete, if requested.

A Member may visit MDC's website at www.manageddentalcare.net to submit a grievance. From the homepage, the Member must select the "Grievance Form" button. The Member will then be able to provide selected information and describe the grievance in detail. Following the completion of the Grievance Form, the Member is given the option to review the completed form prior to submission to MDC. The Member must then select the "Submit" button to send the grievance to MDC. All grievances submitted via MDC's website will be forwarded to the QCL or Designee.

When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work the QCL and provide accommodation, according to Plan guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by the Plan. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.

Managed Dental Care Grievance Process (Cont.)

3. Members may file a grievance up to 180 days following any incident or action that is the subject of the dissatisfaction.
4. No later than five(5) calendar days after receipt of the grievance, an acknowledgement letter (exhibit 3) is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL, that a review is taking place and the grievance will be responded to within 30 days from the date of the Plan's receipt of the grievance in a resolution letter.
5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the dentist or office personnel. MDC may arrange a second opinion, if appropriate.
6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 days from the date of the Plan's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution. The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his or her review of available documentation by initialing a copy of the resolution letter.

The resolution letter to the Member will detail in a clear, concise manner the reasons for the Plan's response. For grievances involving the delay, denial or modification of health care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If the Plan, or one of its clinical reviewers, issues a determination delaying, denying or modifying health care services based in whole or in part on a finding that the proposed health care services are not a covered benefit under the contract that applies to the Member, the letter shall clearly specify the provisions in the contract that exclude that coverage.

Managed Dental Care Grievance Process (Cont.)

7. Within thirty (30) days following receipt of a resolution letter, a Member, or Member's designee, may also request voluntary mediation with the Plan prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care upon completion of mediation. In order to initiate mediation, the Member or designee and the Plan shall voluntarily agree to mediation. Expenses for mediation shall be born equally by both sides. Members only need to participate in the voluntary mediation process for thirty (30) calendar days prior to submitting a complaint to the Department of Managed Health Care. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

The use of voluntary mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care upon completion of mediation.

Following the use of the Voluntary Mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a dentist.

8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.
9. Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function, or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.
10. The plan shall keep all copies of grievances, and the responses to grievances, for a period of five years.
11. The Vice President Operations and Finance who is an officer of the Plan, or designee, has primary responsibility for the Plan's grievance system.
12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by the Plan and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.
13. MDC asserts that there is no discrimination against an enrollee or subscriber (including cancellation of the contract) solely on the grounds that the enrollee filed a complaint.

Managed Dental Care Grievance Process (Cont.)

Grievances Requiring Expedited Review

The Plan will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but not be limited to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Plan.

When the Plan has notice of a grievance requiring expedited review, the grievance process requires the Plan to immediately inform members in writing of their right to notify the Department of Managed Health Care of the grievance. The Plan also will provide members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance.

The following grievance disclosure will be on all member correspondence:

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll free telephone number **1-888-HMO-2219** and a TDD line **1-877-688-9891** for the hearing and speech impaired. The department's internet web site **<http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.

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Option F

Covered Dental Services And Patient Charges - Plan 75 G

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *PCD* selected by the *member*. The *member* must pay the listed *patient charge*. The benefits we provide are subject to all of the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

These *patient charges* are only valid for *covered services* rendered by *participating dentists* in the state of California.

MDG CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
Appointments and Diagnostic Services		
0101	Office Visit - during regular hours - participating general dentist only	No Charge
0102	Broken Appointment (without 24 hours' notice)	\$25.00
0120, 0140, 0150	Oral evaluation	No Charge
0460	Pulp vitality tests	No Charge
0470	Diagnostic casts	No Charge
9310	Consultation (by dentist other than practitioner providing treatment)	No Charge
9430	Office visit for observation - regular hours - no other service performed	No Charge
9440	Emergency office visit - after regularly scheduled office hours	\$50.00
Radiographs		
0210	Intraoral - complete series (including bitewings)	No Charge
0220, 0230, 0240	Intraoral - periapical or occlusal - single film	No Charge
0270, 0272, 0274	Bitewings	No Charge
0330	Panoramic film	No Charge
Preventive Services & Space Maintenance		
1110, 1120	Prophylaxis	No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child . .	No Charge
1310	Nutritional counseling for control of dental diseases	No Charge

Covered Dental Services And Patient Charges - Plan 75 G (Cont.)

MDG CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
1330	Oral hygiene instruction	No Charge
1351	Sealant - per tooth	No Charge
1510	Space maintainer - fixed - unilateral	No Charge
1515	Space maintainer - fixed - bilateral	No Charge
1550	Recementation of space maintainer	No Charge
Restorative		
2110	Amalgam - one surface - primary	No Charge
2120	Amalgam - two surfaces - primary	No Charge
2130	Amalgam - three surfaces - primary	No Charge
2131	Amalgam - four or more surfaces - primary	No Charge
2140	Amalgam - one surface - permanent	No Charge
2150	Amalgam - two surfaces - permanent	No Charge
2160	Amalgam - three surfaces - permanent	No Charge
2161	Amalgam - four or more surfaces - permanent	No Charge
2210	Silicate cement - per restoration	No Charge
2330	Resin/composite - one surface, anterior	No Charge
2331	Resin/composite - two surfaces, anterior	No Charge
2332	Resin/composite - three surfaces, anterior	No Charge
2335	Resin/composite - four or more surfaces or incisal angle, anterior	No Charge
2336	Composite resin crown, anterior - primary	No Charge
2380	Resin/composite - one surface, posterior - primary	No Charge
2381	Resin/composite - two surfaces, posterior - primary	No Charge
2382	Resin/composite - three or more surfaces, posterior - primary	No Charge
2385	Resin/composite - one surface, posterior - permanent	No Charge
2386	Resin/composite - two surfaces, posterior - permanent	No Charge
2387	Resin/composite - three or more surfaces, posterior - permanent	No Charge

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Option F

Crown, Bridge & Other Cast Restorations

2510	Inlay - metallic - one surface*	\$60.00
2520, 6520	Inlay - metallic - two surfaces*	\$75.00
2530, 6530	Inlay - metallic - three or more surfaces*	\$75.00
2543, 6543	Onlay - metallic - three surfaces*	\$80.00
2544, 6544	Onlay - metallic - four or more surfaces*	\$80.00
2702	Crown supporting existing partial denture - in addition to crown	\$125.00
2703	Multiple crown and bridge unit treatment plan - per unit	\$125.00
2740	Crown - porcelain/ceramic substrate	\$100.00
2750, 2751, 2752	Crown - porcelain fused to metal*	\$95.00
2790, 2791, 2792	Crown - full cast metal*	\$90.00
2810, 6780	Crown - 3/4 cast metallic*	\$95.00
6210, 6211, 6212	Pontic - cast metal*	\$90.00
6240, 6241, 6242	Pontic - porcelain fused to metal*	\$95.00
6750, 6751, 6752	Crown - abutment - porcelain fused to metal*	\$95.00
6790, 6791, 6792	Crown - abutment - full cast metal*	\$90.00

Other Restorative Services

2910, 2920, 6930	Recementation inlay, crown, bridge	No Charge
2930, 2931	Prefabricated stainless steel crown	\$10.00

Covered Dental Services And Patient Charges - Plan 75 G (Cont.)

2932	Prefabricated resin crown	\$20.00
2940	Sedative filling	No Charge
2950, 6973	Core buildup, including any pins	\$20.00
2951	Pin retention - per tooth, in addition to restoration	No Charge
2952, 6970	Cast post & core	\$30.00
2954, 6972	Prefabricated post & core	\$25.00
2960	Labial veneer (lamine) - chairside	\$40.00

Endodontics

3110, 3120	Pulp cap	No Charge
3220	Therapeutic pulpotomy	\$10.00
3310	Root canal - anterior	\$70.00
3320	Root canal - bicuspid	\$80.00
3330	Root canal - molar	\$140.00
3346	Root canal - retreatment - anterior	\$80.00
3347	Root canal - retreatment - bicuspid	\$95.00
3348	Root canal - retreatment - molar	\$150.00
3410	Apicoectomy/periradicular surgery - anterior	\$90.00
3421	Apicoectomy/periradicular surgery - bicuspid - first root	\$95.00
3425	Apicoectomy/periradicular surgery - molar - first root	\$100.00
3426	Apicoectomy/periradicular surgery - each additional root	\$40.00
3430	Retrograde filling - per root	\$15.00

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Option F

Periodontics

4210	Gingivectomy or gingivoplasty - per quadrant	\$60.00
4211	Gingivectomy or gingivoplasty - per tooth	\$20.00
4240	Gingival flap procedure - including root planing - per quadrant	\$105.00
4249	Clinical crown lengthening - hard tissue	\$85.00
4260	Osseous surgery - including flap entry, closure - per quadrant - five to eight teeth	\$155.00
4261	Osseous surgery - including flap entry, closure - per quadrant - one to four teeth	\$95.00
4270	Pedicle soft tissue graft procedure	\$100.00
4271	Free soft tissue graft procedure (including donor site surgery)	\$110.00
4341	Periodontal scaling & root planing - per quadrant	\$25.00
4355	Full mouth debridement to enable evaluation and diagnosis	\$15.00
4910	Periodontal maintenance procedures (following active therapy)	\$15.00
4920	Unscheduled dressing change (by other than treating dentist)	No Charge
9951	Occlusal adjustment - limited - per visit	No Charge

Prosthodontics (Removable)

5110, 5120	Complete denture (including routine post delivery care)	\$110.00
5130, 5140	Immediate denture (including routine post delivery care)	\$110.00

Partial dentures (including routine post delivery care):

5211, 5212	Resin base - including clasps, rests, teeth	\$90.00
5213, 5214	Cast metal framework with resin base - including clasps, rests, teeth	\$130.00

Repairs and Adjustments

Covered Dental Services And Patient Charges - Plan 75 G (Cont.)

5410, 5411, 5421,		
5422	Denture adjustments	\$5.00
5510, 5610	Repair denture base	No Charge
5520, 5640	Replace missing or broken teeth -per tooth	No Charge
5630	Repair or replace clasp	No Charge
5650	Add tooth to existing partial	No Charge
5660	Add clasp to existing partial	No Charge
5710, 5711, 5720,		
5721	Rebase denture	No Charge
5730, 5731, 5740,		
5741	Reline denture (chairside)	No Charge
5750, 5751, 5760,		
5761	Reline denture (laboratory)	No Charge
5820, 5821	Interim partial denture (stayplate)	\$45.00
5850, 5851	Tissue conditioning	No Charge
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Option F

Oral Surgery

7110, 7120	Extraction - single tooth	\$5.00
7130	Root removal - exposed roots	\$15.00
7210	Surgical removal of erupted tooth	\$35.00
7220	Removal of impacted tooth - soft tissue	\$50.00
7230	Removal of impacted tooth - partially bony	\$70.00
7240	Removal of impacted tooth - completely bony	\$80.00
7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$85.00
7250	Surgical removal of residual tooth roots (cutting procedure)	\$40.00
7270	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$60.00
7280	Surgical exposure of impacted or unerupted tooth for orthodontic reasons	\$90.00
7281	Surgical exposure of impacted or unerupted tooth to aid eruption	\$60.00
7285	Biopsy of oral tissue - hard	\$45.00
7286	Biopsy of oral tissue - soft	\$40.00
7310	Alveoplasty in conjunction with extractions - per quadrant	\$35.00
7320	Alveoplasty not in conjunction with extractions - per quadrant	\$45.00
7450	Removal of odontogenic cyst/tumor - up to 1.25 cm	\$60.00
7451	Removal of odontogenic cyst/tumor - over 1.25 cm	\$110.00
7470	Removal of exostosis - maxilla or mandible	\$85.00
7510	Incision & drainage of intraoral abscess	\$25.00
7960	Frenectomy (separate procedure)	\$60.00

Miscellaneous Services

9110	Palliative (emergency) treatment	No Charge
9215	Local anesthesia	No Charge

+ Covered Services are subject to this plan's exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

* There will be an additional *patient charge* for the actual cost of gold/high noble metal for these procedures.

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Option F

MDC CODES+	DESCRIPTION OF SERVICE	PATIENT CHARGE
	Orthodontics	
8601	Orthodontic evaluation and consultation	\$100.00
8602	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos	\$150.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: dependent child to age 18 (as determined by the <i>member's</i> age on the date of banding)	\$1975.00
8070, 8080, 8090	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months: employee, spouse and dependent child over age 18 (as determined by the <i>member's</i> age on the date of banding)	\$2175.00
8670	Periodic comprehensive orthodontic treatment visit	No Charge
8680	Orthodontic retention	\$300.00

+ Covered Services are subject to this *plan's* exclusions, limitations and *plan* provisions. Other codes may be used to describe Covered Services.

* These Orthodontic *patient charges* are valid only for authorized services rendered by *participating orthodontists* in the State of California.

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Option F

Additional Conditions on Covered Services

General Guidelines for Alternative Procedures There may be a number of accepted methods of treating a specific dental condition. When a *member* selects an *alternative procedure* over the service recommended by the *PCD*, the *member* must pay the difference between the *PCD's* usual charges for the recommended service and the *alternative procedure*. He or she will also have to pay the applicable *patient charge* for the recommended service.

When the *PCD* recommends a crown, the *alternative procedure* policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The *member* must pay the applicable *patient charge* for the crown actually placed. The *member* must also pay the additional cost of high noble metal, if high noble metal is selected.

Crowns, Bridges and Dentures A crown is a covered service when it is recommended by the *PCD*. The replacement of a crown or bridge is not covered within 5 years of the original placement under the *plan*.

The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by reline, rebase or repair. Construction of new dentures may not exceed one each in any 5 year period from the date of previous placement under the *plan*.

Additional Conditions on Covered Services (Cont.)

The benefit for complete dentures includes all usual post-delivery care including adjustments for six months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for six months; and (b) does not include required future rebasing or relining procedures or a complete new denture.

Multiple Crown/Bridge Unit Treatment Fee A *member's* approved treatment plan may include 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth. In such case, the *member* must pay both: (a) the usual crown or bridge *patient charge* for each unit of crown or bridge; and (b) an additional charge per unit. These charges are shown in the Covered Dental Services And Patient Charges section.

Crown Supporting Existing Partial Denture A crown may be: (a) placed under an existing partial denture; and (b) be customized to physically support the metal framework of the partial denture. In such case, the *member* must pay the *patient charge* for a crown supporting an existing partial denture. This charge is shown in the Covered Dental Services And Patient Charges section. This charge is in addition to the *patient charge* for the crown or bridge unit itself. The *patient charge* for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the *member* must pay the *patient charge* for a multiple crown/bridge unit treatment plan.

Pediatric Specialty Services During a *PCD* visit, a *member* under age 6 may be unmanageable. In such case, the *member* may be referred to a *participating pediatric specialist* for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the *member* must return to the *PCD* for further services. Later referrals to the *participating pediatric specialist*, if any, must first be authorized by MDC. Any services performed by a *pediatric specialist* after the *member's* 6th birthday will not be covered. And the *member* must pay the *pediatric specialist's* usual charges for such services.

Second Opinion Consultation A Member or the Member's *PCD* may request the Member consult another Dentist for a second opinion regarding services recommended or performed by: (a) his or her *PCD*; or (b) a participating specialist through an authorized referral. To have a second opinion consultation covered by MDC, you must call or write Member Services for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the Plan. Authorizations for second opinions are valid for sixty (60) days from the date of approval.

The request for a second opinion may be approved at the time of the request, or within 72 hours if an emergency exists.

A Member Services Representative will help you identify a Participating Dentist to perform the second opinion consultation. You may request a second opinion with a non-participating general Dentist or specialist dentist. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist. Once the second opinion consultation is completed and the Second Opinion Form is returned to the Member Services Representative, you and your dentist will receive a copy of the findings and recommendations.

Additional Conditions on Covered Services (Cont.)

The Plan's benefit for a second opinion consultation is \$50.00. If a participating dentist is the consultant, there is no cost to you. If a non-participating dentist is the consultant, you may pay any portion of his or her fee over \$50.

We will not deny a request for a second opinion until it has been reviewed by the Dental Director or Designee. All appeals of denials will be reviewed by the Grievance and/or Peer Review Committee. If the request for a second opinion is denied, the Member and/or PCD will receive a written notice of the reasons for the denial. The notice will also state the Member and/or PCD has the right to contact the Member Services Department to file a grievance.

MDC has a written policy describing the timeline for second opinions and how we administer the second opinion program. You may request a complete copy of MDC's written policy by contacting the Member Services Department at 800-273-3330, or by mail at P.O. Box 4391, Woodland Hills, CA 91367.

Noble and High Noble Metals

The *plan* provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, *you* must pay: (a) the usual *patient charge* for the inlay, onlay, crown or fixed bridge; plus (b) an added charge equal to the actual laboratory cost of the high noble metal.

CGP-3-MDCGG

B850.0821

Option F

Orthodontic Treatment

This *plan* covers orthodontic services as shown in Covered Dental Services And Patient Charges. Coverage is limited to one course of treatment per *member* per lifetime. Treatment must be: (a) preauthorized by MDC; and (b) performed by a *participating orthodontist*.

The *plan* covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, *you* must pay an added charge for each added month of treatment. Such charge is based on the *participating orthodontist's* contracted fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under this *plan*.

Additional Conditions on Covered Services (Cont.)

The covered service for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. *You* must pay for additional fixed or removable appliances. The benefit for orthodontic retention covers: (a) any and all necessary fixed and removable appliances; and (b) related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances made with: (a) clear; (b) ceramic; (c) white or other optional material; or (d) lingual brackets.

If a *member* has orthodontic treatment associated with orthognathic surgery, the *plan* provides its standard orthodontic benefit. Orthognathic surgery is a non-covered procedure involving the surgical moving of teeth. *You* must pay any added charges related to: (a) the orthognathic surgery; and (b) the complexity of the orthodontic treatment. The added charges will be based on the *participating orthodontist's* usual and customary charge.

CGP-3-MDCGG2-A

B850.0822

Option F

Limitations on Benefits for Specific Covered Services

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis) or periodontal maintenance procedure - 2 services in any 12 month period. One periodontal maintenance procedure may be performed by a *participating periodontist* if done within 3 to 6 months following completion of approved, active periodontal therapy by the *participating periodontist*. Such therapy includes periodontal scaling and root planing or periodontal surgery.
- Fluoride treatment - up to the 18th birthday - 2 in any 12 month period.
- Full mouth x-rays - one set in any 3 year period unless diagnostically necessary.
- Bitewing x-rays - 2 sets in any 12 month period unless diagnostically necessary.
- Panoramic x-rays - one in any 3 year period unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one per tooth in any 3 year period.
- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one service per quadrant or area in any 3 year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one service per area in any 3 year period.
- Periodontal scaling and root planing - one service per quadrant in any 12 month period.

Additional Conditions on Covered Services (Cont.)

- *Emergency dental services* when more than 50 miles from the *PCD's* office - up to \$50.00 per incident.
- Reline of a complete or partial denture - one per denture in any 12 month period.
- Rebase of a complete or partial denture - one per denture in any 12 month period.
- Second opinion consultation - when approved by MDC, up to \$50.00.

CGP-3-MDCLMT

B850.0199

Option F

Exclusions

- We won't pay for:
- any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law. This will apply even if the *member* fails to claim his or her rights to such benefit.
 - hospitalization costs (and any associated charges, including but not limited to, physician charges, prescriptions or medications), for any dental services performed on an inpatient or outpatient basis in a hospital.
 - any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.
 - any treatment of congenital and/or developmental malformations. This will not apply to an otherwise covered service involving: (a) congenitally missing teeth; or (b) supernumerary teeth.
 - any oral surgery requiring the setting of a fracture or dislocation.
 - dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
 - any treatment or appliance: (a) which, in the opinion of the *participating dentist*, is not necessary for maintaining or improving the *member's* dental health; or (b) which is solely for cosmetic purposes.
 - precision attachments, stress breakers, magnetic retention or overdenture attachments.
 - the use of: (a) general anesthesia; (b) intramuscular sedation; (c) intravenous sedation; or (d) inhalation sedation, including but not limited to nitrous oxide.
 - any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice; or (b) which is considered to be experimental in nature.
 - replacement of a lost, missing or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.

Exclusions (Cont.)

- any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD*; or (b) treatment by a specialist without referral from the *PCD* and MDC approval.
- treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for periodontal reasons.
- any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- dental services received from any *dentist* other than the selected and assigned *PCD*, unless expressly authorized in writing by the *plan*. This will not apply to covered *emergency dental services*.
- cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- treatment which requires the services of a *prosthodontist*.
- treatment which requires the services of a *pediatric specialist*, after the *member's* 6th birthday.
- consultations for non-covered services.
- any procedure not listed as a covered service.
- any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- inlays, onlays, crowns or fixed bridges started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. (Inlays, onlays, crowns or fixed bridges are: (a) started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented.)
- root canal treatment started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. (Root canal treatment is: (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.)
- inlays, onlays, crowns or fixed bridges started (as defined above) by a *non-participating dentist*. This will not apply to covered *emergency dental services*.
- dentures or orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan*. (Dentures are started when the impressions are taken. Orthodontic treatment is started when the teeth are banded.)

Exclusions (Cont.)

- root canal treatment started (as defined above) by a *non- participating dentist*. This will not apply to covered *emergency dental services*.
- extractions performed solely to facilitate orthodontic treatment.
- extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- orthognathic surgery and associated incremental charges. Orthognathic surgery is a procedure which involves the surgical moving of teeth.
- procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate either hemisection or root amputation; and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- procedures, appliances or devices: (a) to guide minor tooth movement; or (b) to correct or control harmful habits.
- any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- replacement or repair of orthodontic appliances damaged due to the neglect of the *member*.

CGP-3-MDCEXC-B

B850.0824

Option F

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

Act means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

CGP-3-MDCD

B850.0826

Option F

Combined Evidence of Coverage and Disclosure Form means this booklet issued to *you*, which summarizes the essential terms of this *plan*.

CGP-3-MDCD2

B850.0207

Option F

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

CGP-3-MDCD3

B850.0208

Option F

Dependent means the spouse and dependent children of the employee as defined herein under the section entitled Eligible Dependents.

CGP-3-MDCDMST-C

B850.1472

Option F

Emergency Dental Services are defined as dental services limited to procedures administered in a hospital, dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under this plan.

CGP-3-MDCD5

B850.0828

Option F

Employee or You means a person: (a) who meets your *employer's* eligibility requirements; and (b) for whom your *employer* makes monthly payments under this *plan*.

CGP-3-MDCD6

B850.0213

Option F

Employer or Planholder means your *employer* or other entity: (a) with whom or to whom this *plan* is issued; and (b) who agrees to collect and pay the applicable premium on behalf of all its *members*.

CGP-3-MDCD7

B850.0214

Option F

Member means *you* and any of your eligible *dependents* : (a) as defined under the eligibility requirements of this *plan*; and (b) as determined by your *employer*, who are actually enrolled in and eligible to receive benefits under this *plan*.

CGP-3-MDCD8

B850.0215

Option F

Non-Participating Dentist means any *dentist* who is not under contract with MDC to provide dental services to *members*.

CGP-3-MDG-DEF9

B850.0217

Option F

Participating Dentist means a *dentist* under contract with MDC.

CGP-3-MDCD10

B850.0829

Option F

Participating General Dentist means a *dentist* under contract with MDC: (a) who is listed in MDC's directory of *participating dentists* as a general practice *dentist*; and (b) who may be selected as a *PCD* by a *member* and assigned by MDC to provide or arrange for a *member's* dental services.

CGP-3-MDCD11

B850.0219

Option F

Participating Specialist means a *dentist* under contract with MDC as an: (a) *endodontist*; (b) *pediatric specialist*; (c) *periodontist*; (d) *oral surgeon* or (e) *orthodontist*.

CGP-3-MDC12-B

B850.0220

Option F

Patient Charge means the amount, if any, specified in the Covered Dental Services And Patient Charges section of this *plan*. Such amount is the patient's portion of the cost of covered dental services.

CGP-3-MDCD13

B850.0222

Option F

Plan means the MDC group *plan* for dental services described in this booklet.

CGP-3-MDCD14

B850.0223

Option F

Primary Care Dentist (PCD) means a dental office location: (a) at which one or more *participating general dentists* provide *covered services* to *members*; and (b) which has been selected by a *member* and assigned by MDC to provide and arrange for his or her dental services.

CGP-3-MDCD15

B850.0224

Option F

Service Area means the geographic area in which MDC is licensed to provide dental services for *members*.

CGP-3-MDCD16

B850.0225

Option F

We, Us, Our and MDC mean Managed Dental Care of California.

CGP-3-MDCD17

B850.0226

Option F

COORDINATION OF BENEFITS

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a Member has coverage under more than one plan. The primary carrier pays up to its maximum liability and the secondary carrier considers the remaining balance for covered services up to, but not exceeding, the benefits that are available and the Dentist's actual charge.

Determination of primary coverage is as follows:

For Adults A plan covering an adult as an Employee is primary, and determines its benefits first. A plan covering an adult as a Dependent (through a plan from a spouse's Employer) is secondary, and determines its benefits only after the primary plan's benefits have been paid.

If a person is covered as an Employee or a former Employee under more than one plan, a plan which covers him or her as an active Employee determines benefits before any Plan covering the person as a laid-off or retired Employee. Otherwise, the plan covering that person longer determines its benefits before the other plan does.

Coordination of Benefits (Cont.)

For Dependent Children The determination of primary and secondary coverage for Dependent Children covered by two parents' plans follows the birthday rule. The plan of the parent with the earlier birthday (month and day, not year) is the primary coverage. Different rules apply for the children of divorced or legally separated parents; contact the Member Services Department if you have any questions.

Coverage under MDC and another prepaid dental plan: When an MDC Member has coverage under another prepaid plan, whether MDC is the primary or the secondary coverage, PCD may not collect more than the applicable copayment from the Member.

Coverage under MDC and a traditional or PPO fee for service plan: When a Member is covered by MDC and a fee for service plan, the following rules will apply:

When MDC is the primary plan (e.g., when an MDC Member also has fee for service coverage under a spouse's plan), you may only bill the secondary carrier for the Patient Charge amount. Any payment made by the secondary carrier must be credited against the Member's payment.

When MDC is the secondary plan (e.g., when an MDC Member's eligible Dependent spouse has fee for service coverage through his or her Employer), PCD should bill the primary plan first. The primary payment is then credited against the Patient Charge. The Member will be responsible for a payment only if the primary carrier's payment is less than the applicable MDC Copayment.

When an MDC Member with other coverage receives authorized services from a Participating Specialist Dentist, and MDC is primary, the MDC benefits are paid without regard to the other coverage. When MDC is the secondary plan, any payment made by the primary carrier is credited against the copayment. MDC will then issue payment of the Specialist up to the unpaid remainder of the fee schedule amount. In many cases the Member will have no out-of-pocket expenses.

MDC will not coordinate or pay for the following:

Any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease law.

Treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

CGP-3-MDC-COB

B850.0830

Option F

STATEMENT OF ERISA RIGHTS

As a participant, an employee is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants will be entitled to:

Receive Information about the Plan and Benefits:

- a. Examine, without charge, at the plan administrator's office and at other specified locations such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.
- b. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- c. Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Dental Health Plan Coverage

Continue dental health care coverage for the employee, his or her spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. The employee and his or her dependents may have to pay for such coverage. The employee should review the summary plan description and the documents governing the plan on the rules governing his or her COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including the employer, an employee's union, or any other person may fire an employee or otherwise discriminate against him or her in any way to prevent the employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

Statement of Erisa Rights (Cont.)

Enforcement of An Employee's Rights If an employee's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps an employee can take to enforce the above rights. For instance, if an employee requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay the employee up to \$110 a day until he or she receives the material, unless the materials were not sent because of reasons beyond the control of the administrator. If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if an employee is discriminated against for asserting his or her right, the employee may seek assistance from the U.S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person he or she sued to pay these costs and fees. If the employee loses, the court may order him or her to pay these costs and fees, for example, if it finds that the employee's claim is frivolous.

Assistance with Questions If an employee has questions about the plan, he or she should contact the plan administrator. If an employee has questions about this statement or about his or her rights under ERISA, or if the employee needs assistance in obtaining documents from the plan administrator, he or she should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210. An employee may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

CGP-3-MDCER

B850.0831

COMBINED EVIDENCE OF COVERAGE AMENDMENT

(To be attached to Your Combined Evidence of Coverage)

Amendment Effective: The later of (i) the effective date of your certificate; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by Guardian.

This rider amends Your Combined Evidence of Coverage as follows:

The section of Your Combined Evidence of Coverage entitled "When Coverage Ends" is replaced by the following:

When Coverage Ends Subject to any continuation of coverage privilege which may be available to You or Your Dependents, coverage under this Plan ends when Your Employer's coverage terminates. Your and Your Dependents' coverage also ends on the first to occur of:

1. The end of the period for which You have made Your last premium payment, if You are required to pay any part of this Plan;
2. For You, the end of the month in which You are no longer eligible for coverage under this Plan;
3. For Your Dependents:
 - For Your Dependent spouse, the end of the month in which Your spouse is no longer a Dependent as defined in this Plan;
 - For Your Dependent child, the end of the month in which Your child is no longer a Dependent as defined in this Plan;
4. The date on which You or Your Dependent no longer resides or works in the Service Area;
5. The end of the month during which Your Employer receives written notice from You requesting termination of coverage for You or Your Dependents, or on such later date as You may request by the notice;
6. The date of a Member's entry into active military duty. But, coverage will not end if the Member's duty is temporary. Temporary duty is duty of 31 days or less;

7. 30 days after MDC sends written notice to a Member advising that his or her coverage will end because the Member has: (a) knowingly given false information in writing on his or her enrollment form; or (b) misused his or her ID card or other documents provided to obtain benefits under this Plan; or (c) otherwise acted in an unlawful or fraudulent manner regarding Plan services and benefits; or
8. 30 days after MDC sends written notice to a Member, where MDC has: (a) addressed the failure of the Member and his or her PCD to establish a satisfactory patient-dentist relationship; (b) offered the Member the opportunity to select another PCD; and (c) described the changes necessary to avoid termination.

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



Eric Krohne, President



Larry Weiss, Assistant Vice President
and Controller

CGP-3-MDG-DENDEP-17-CA

B850.1582

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN 75	Deductibles	Lifetime Maximums	Professional Services			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			No Charge	Prophylaxis - \$0; Flouride - \$0; Sealants - \$5; Space Maintainers - \$0 - \$20	Amalgam - \$0; Resin - \$0; Crowns - \$90 - \$100; Inlays & Onlays - \$60 - \$80; Miscellaneous: Restorative Services - \$0 - \$40	Pulp Cap - \$0; Pulpotomy - \$10; Root Canals - \$70 - \$140; Retreatments - \$80 - \$150; Apicoectomy: - First Root - \$80 - \$100; Each Additional Root - \$40; Retrograde Filling - Per Root - \$15
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member Per Lifetime	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period	Prophylaxis - 2 In Any 12 Month Period; Flouride Treatment Up To 18th Birthday - 2 In Any 12 Month Period; Sealants - Limited To Molars, Up To 16th Birthday, One Per Tooth In Any 3 Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

B850.0859

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

Plan 75 (Continued)	Professional Services (Continued)				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Services (Continued)	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Crown Lengthening; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor	Comprehensive Treatment; Retention; Evaluation And Consultation; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - \$20 - \$60*; Gingival Flap Procedure - \$105; Osseous Surgery - \$95 - \$155*; Scaling & Root Planing - \$25; Soft Tissue Graft - \$100 - \$110; Crown Lengthening - \$85; Miscellaneous Periodontal Services - \$0 - \$15 *Limited - Quadrant	Complete Dentures - \$110; Partial Dentures - \$45 - \$130; Reline - \$65 - \$100; Repair - \$30 - \$120; Denture Adjustment - \$20	Simple Extractions - Removal Of Complete Bony Impactions - \$0 - \$90; Biopsy, Oral Tissue - \$40 - \$45; Alveoplasty - \$35 - \$45 Incision And Drainage - \$25 Frenectomy/ Frenulectomy - \$60; Removal Of Cyst/Tumor - \$60 - \$110	To Age 18 - \$1975 Over Age 18 - \$2175; Retention - \$300; Evaluation and Consultation - \$100; Treatment Plan And Records - \$150	Office Visit - \$0 - \$5; After Hours Office Visit - \$50; Palliative Treatment - \$0 Local Anesthesia - \$0

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

Plan 75 (Continued)	Professional Services (Continued)				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations (Continued)	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/ Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member Per Lifetime; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

B850.0860

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDG 75 0899

B850.0896

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

PLAN 75	Outpatient Services	Hospitalization Service	Emergency Health Coverage		Ambulance Services	Prescription Drug Services
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to \$50 Reimbursement Per Incident	Not Covered*	Not Covered*
PLAN 75 (CONT.)	Durable Medical Equipment	Mental Health Services	Chemical Dependency Services	Home Health Services	Other	
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDG 75 0899

B850.0861

COMBINED EVIDENCE OF COVERAGE AMENDMENT

This Rider amends the Combined Evidence of Coverage as follows and is effective on 07/01/2017.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of a *Member's* condition consistent with good professional dental practice.

Managed Dental Care of California's dental coverage organization network (MDC network) has adequate capacity and availability of *participating dentists* to offer appointments for Covered Dental Services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of a *Member's* condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if a *Member* is requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating *dentist*, acting within the scope of the *dentist's* practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on a *Member's* health.

When it is necessary for a *Member's dentist* or a *Member* to reschedule an appointment, the appointment will be promptly rescheduled by a *Member's dentist* in a manner that is:

- Appropriate for a *Member's* dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for a *Member* at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Participating dentists are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how a *Member* may obtain urgent or emergency care, including how to contact another *dentist* who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the *participating dentist* does not answer and a *Member* has an emergency, a *Member* may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any *dentist*.

Telephone triage or screening services are to be provided in a timely manner appropriate for a *Member's* condition. During normal business hours the waiting time for a *Member* to speak by telephone with a knowledgeable and competent customer service representative regarding a *Member's* questions and concerns will not exceed 10 minutes.

If a *Member* has questions or wants to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1- 800-273-3330 or the toll-free number on the *Member's* ID card.

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

Managed Dental Care of California

The image shows two handwritten signatures in black ink. The signature on the left is 'Eric Krohne' and the signature on the right is 'Larry Weiss'.

Eric Krohne, President

Larry Weiss, Assistant Vice President
and Controller

B850.1604

All Options

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

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

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

What is Protected Health Information (PHI):

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

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

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

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

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

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

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

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

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

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

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

B998.0051

All Options

Guardian is required to use or disclose your PHI :

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

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

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

Other Uses and Disclosures .

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

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

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

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0052

All Options

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B998.0053

All Options

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

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

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

How to Contact Us:

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

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

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

B998.0055

This Booklet Includes All Benefits For Which You Are Eligible.

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

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

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Term Life Insurance described in this Certificate is attached to the group Policy effective September 1, 2007. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP TERM LIFE INSURANCE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) satisfy any necessary Proof of Insurability requirements; and (d) all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

FOR INSURED PERSONS AGE 65 OR OLDER WHO PAY SOME OR ALL OF THE COST OF THIS INSURANCE: YOU HAVE A 30 DAY EXAMINATION PERIOD AFTER THE RECEIPT OF THIS CERTIFICATE DURING WHICH YOU MAY CANCEL THE COVERAGE AND RETURN THIS CERTIFICATE BY MAIL OR OTHER DELIVERY METHOD. SUCH RETURN WILL VOID THE CERTIFICATE FROM THE BEGINNING, AND THE PARTIES WILL BE IN THE SAME POSITION AS IF A CERTIFICATE HAD NOT BEEN ISSUED. ALL PREMIUMS PAID WILL BE FULLY REFUNDED IN A TIMELY MANNER NOT LATER THAN 30 DAYS AFTER THE COMPANY RECEIVES THE RETURNED CERTIFICATE.

Policyholder: HILTON WATERFRONT BEACH RESORT
Group Policy Number: 00429264

The Guardian Life Insurance Company of America



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Estep, Vice President

B401.1934

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COMPLAINT NOTICE

This notice is to advise You that should any complaints arise regarding this insurance You may contact the Guardian at the following address or phone number:

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, NY 10001
(212) 598-8000

If You feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)
Website: www.insurance.ca.gov/01-consumers/

B401.1936

GENERAL PROVISIONS

The Contract and Limitation Of Authority

The entire contract between the Policyholder and Us consists of:

- The Policy;
- The Schedule of Premium Rates;
- This Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; (5) and the application.

In the event of a conflict, the Policy shall reign.

We can amend the Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by the Policyholder and agreed to by Us; or
- On any date Our obligation under the Policy with respect to the Policyholder, or under this Certificate with respect to You, is changed because of statutory or other regulatory requirements.

Upon request, You may obtain a copy of the Policy from Us.

If We amend this Certificate, except upon request made by You, We must give You written notice of such change. Any amendments to this Certificate will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an enrollment form or other required form; and
- We have received any required premium.

If Proof of Insurability is required, You will not be covered unless You satisfy the Proof of Insurability requirements stated in the Certificate and Schedule of Benefits.

Incontestability

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

No statement in any application, made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for up to two years from the Effective Date of the Policy.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

Physical Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under the Certificate as often as We feel is reasonably necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.1937

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE - EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Group Term Life coverage if You are:

- In an eligible class of Employees;
- An active Full time Employee;
- Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Group Term Life coverage if You are:

- A temporary or seasonal Employee.

Enrollment Requirement If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

Proof Of Insurability Part or all of Your insurance amounts may be subject to proof that You are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You provide such proof to Us and We approve it in writing.

The Waiting Period If You are in an eligible class, You are eligible for Group Term Life insurance under this Certificate after You complete the service waiting period, if any, established by the Employer.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple life insurance coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.3124

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage starts. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on the date You sign Your enrollment form. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.3130

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

Any part of Your coverage which is subject to Proof Of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.3131

All Options

Delayed Eligibility Date For Employee Voluntary Term Life Insurance

If due to sickness or injury, You are not Actively at Work and working the minimum required number of hours of an Employee in Your eligible class, on the date Your Voluntary Term Life coverage is scheduled to start, We will postpone coverage for an otherwise covered loss for any condition that prevents you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.3132

All Options

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
 - Disability;
 - Death;
 - Retirement;
 - Layoff;

- Leave of absence;
 - The end of employment; and
 - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
 - The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
 - The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
 - The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. And, You may have the right to replace certain group benefits with converted policies. The Employer will notify you of any conversion options available.

B400.3135

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance for the amount of voluntary term life insurance for which You are insured on Your last day of Active Work, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and are receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date We request it. Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months.

If You become Disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.3137

All Options

**ELIGIBILITY FOR GROUP TERM LIFE COVERAGE
DEPENDENT COVERAGE**

B400.3143

All Options

**Eligible Dependents For Dependent Voluntary
Term Life Insurance**

Your eligible dependents are Your:

- Spouse who is under age 70; and
- dependent children from birth until they reach age 26.

B400.3190

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must be chiefly dependent upon on You for support and maintenance. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

B401.1940

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.3201

All Options

**Continuing Coverage For Dependent Children
Past the Limiting Age**

If You have a child or children who:

- Is/are incapable of self-sustaining employment by reason of an intellectual disability or physical handicap; and

- Is/are chiefly dependent upon You for support and maintenance,

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied.

Each such child:

- Must have an intellectual disability or physical handicap that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group life policy that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Remains:
 - Incapable of self-sustaining employment; and
 - Primarily dependent upon You for most of his or her support and maintenance; and

You must send Us written proof, and we must approve such proof, of the child's disability or handicap and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B401.1941

All Options

Proof Of Insurability

Part or all of Your dependent insurance amounts may be subject to proof that they are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. Your dependents will not be covered for any amount that requires Proof of Insurability until You provide that proof to Us and We approve that proof in writing.

B400.3203

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception shown below and to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

Initial Dependents If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.3204

All Options

Exception We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is confined to a hospital or other health care facility or home confined.

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date of his or her discharge from such facility or his or her home confinement ends.

If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B401.1943

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends; or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your class.

If You are required to pay 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. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary life coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70.

Read this Certificate carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And, they may have the right to replace certain group benefits with converted policies.

B400.3210

All Options

EMPLOYEE TERM LIFE INSURANCE

B400.3211

All Options

Voluntary Term Life Insurance

Subject to the limitations and exclusions shown below, if You die while covered for this Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits for the plan of voluntary term life insurance You have elected. The voluntary term life insurance amount may be subject to reductions. These reductions are also shown in the Schedule Of Benefits. Your voluntary term life insurance amount, a part of it, or increases in such amount may not become effective until You submit Proof Of Insurability to Us, and We approve it in writing. These requirements are also shown in the Schedule Of Benefits.

B401.2790

All Options

The Choices You may elect to be covered for any of the plans of employee voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B400.3214

All Options

You may switch to another plan of voluntary term life insurance during the voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered under the new plan as of the transfer date shown in the Schedule Of Benefits. You must notify the Employer of any desired switch.

B400.3216

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your death is due to suicide, and if such death occurs within 2 years from Your voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your death is due to suicide, and if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary Group Term Life insurance plan Your Employer had with another insurer, You will be given credit for the amount of time covered under the prior plan's Suicide Exclusion if:

- You were covered under the prior plan when it ended;
- You Enrolled for voluntary Group Term Life insurance under this Certificate on or before this Certificate's effective date; and
- You are Actively At Work on the effective date of this Certificate.

If You satisfy these conditions We will credit any time covered under the prior term life plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your voluntary term life insurance benefit under this Certificate if it is more than the benefit for which You were insured under the prior term life plan. In this case, We limit the benefit to the amount You would have been entitled to under the prior term life plan.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This Life Insurance If You assign this insurance, You permanently transfer all Your rights under this insurance to the assignee. Only one of the following can be an assignee:

- Your Spouse;
- One of Your parents or grandparents;
- One of Your children or grandchildren;
- One of Your brothers or sisters; or
- The trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment. Assigning this life insurance may limit Your ability to exercise certain rider benefits.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We reimburse up to \$5,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and AD&D contracts will not exceed \$5,000.

B401.1945

CONVERTING THIS EMPLOYEE VOLUNTARY TERM LIFE INSURANCE

**If Employment Or
Eligibility Ends**

Your group life insurance ends on the date:

- Your active Full-Time employment ends; or
- You stop being a member of an eligible class.

If Your group life insurance ends, Your Employer is responsible for providing You Notice of Your Right to Convert.

If You are not Totally Disabled, You can apply to convert Your Employee group voluntary life insurance to a permanent life insurance policy.

You can apply to convert up to the full amount of voluntary life insurance for which You were insured under this Certificate on the date Your insurance ended, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

**If This Certificate
Ends Or Group Life
Insurance Is
Discontinued**

Your group life insurance also ends:

- If this Certificate ends; or
- Life insurance is discontinued from this Certificate for all Employees or for Your class.

If Your group life insurance ends for either of these reasons, You may apply to convert Your Employee group voluntary life insurance to a Converted Policy.

You can apply to convert to a permanent life insurance policy, if

- You are not Totally Disabled; and
- You have been insured by a Guardian group life insurance plan or a group plan it replaces for at least five consecutive years.

However, the amount of life insurance that You can convert in either scenario is limited to the lesser of:

- \$2,000, or
- The amount of Your voluntary life insurance under this Certificate, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

**If You Are Totally
Disabled**

Your group life insurance ends on the date:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class;
- This Certificate ends; or

- Life insurance is discontinued from this Certificate for all Employees or for Your class;

and

- You are Totally Disabled; and
- You are eligible for Waiver of Premium Benefits pursuant to the Waiver of Premium Benefit Rider, but You have not yet been approved for the Waiver of Premium of Benefit,

You can apply to convert Your group term life insurance to:

- A permanent life insurance policy; or
- Interim term life insurance coverage.

You can apply to convert up to the full amount of voluntary life insurance for which You are insured under this Certificate on the date Your insurance ends, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

However, if You have coverage under this Certificate's Exception to When Employee Coverage Starts, You may not convert if You are eligible or could become eligible under the prior plan's waiver of premium provision.

If You have converted and are later approved for this Certificate's Waiver of Premium Benefit, the Converted Policy will be cancelled as of the date You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit.

Interim Term Life Insurance

You may choose to apply to convert to interim term life insurance coverage if:

- You are Totally Disabled; and
- You may be eligible for Waiver of Premium Benefits based upon Your age, but You have not yet been approved for the Waiver of Premium Benefit.

If interim term life insurance coverage is issued to You, it can remain in force for up to one year from the date the interim term life insurance coverage goes into force and effect.

If You are approved for this Certificate's voluntary Waiver of Premium Benefit during this year, the interim term life insurance coverage will be cancelled as of the date that You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit. If You have not been approved for this Certificate's voluntary Waiver of Premium Benefit, the interim term life insurance coverage will end exactly one year from the first day said coverage goes into force and effect, and Your life insurance will be converted to a permanent life insurance policy. Premiums for the permanent life insurance policy will be based on Your age as of the date You convert from the interim term life insurance coverage.

If You are Totally Disabled, but You are not eligible for the Waiver of Premium Benefit based on Your age, You can apply to convert to a permanent life insurance policy.

How and When to Convert To obtain a Converted Policy, We must receive a written application fully completed by You, and all required premiums within the Conversion Period. Your Employer is responsible for providing You with Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. We will not ask for proof that You are insurable. In order to obtain a Converted Policy, You must satisfy all conditions required to convert within the Conversion Period.

Coverage will begin under the Converted Policy when We receive:

- A written application fully completed by You; and
- All required premiums during the Conversion Period.

Death During The Conversion Period We will pay a death benefit equal to the amount of life insurance that could have been converted if:

- You die within the Conversion Period; and
- But for Your death, You would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to the beneficiary You designate under the group Certificate. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.3232

All Options

Portability And Conversion If You choose to convert, this Certificate's portability privilege will not be available. In the event that a person would be eligible to both convert and to port, only one of these privileges may be chosen. Coverage under both a Conversion Policy and a portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

B400.3234

DEPENDENT TERM LIFE INSURANCE

B400.3235

Voluntary Term Life Insurance

A Subject to the limitations and exclusions shown below, If Your dependent dies while insured for this benefit, We will pay You the amount shown in the Schedule Of Benefits. If You are not living when Your dependent dies, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit to the Spouse's estate. If there is no established estate, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouse's children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your child's custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your child's estate;
- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your child's siblings.

We have the option of paying up to \$500 of this benefit to any person who incurred expenses for your dependent's funeral.

B401.2793

All Options

The Choices: You may elect coverage of any of the plans of dependent Spouse voluntary term life insurance and any of the plans of dependent child voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered for one Spouse plan and one child plan at a time. You must notify the Employer of Your election and pay the required premium.

You may switch to another Spouse and child plan during the dependent voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered for the new plan as of the transfer date shown in the Schedule of Benefits. You must notify the Employer of any desired switch.

B400.3242

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your dependent's death is due to suicide, if such death occurs within 2 years from his or her voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your dependent's death is due to suicide, if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary term life insurance plan Your Employer had with another insurer, your dependent may be given credit for the amount of time covered. If your dependent was:

- Covered under the prior plan when it ended;
- Enrolled for insurance under this Certificate on or before this Certificate's effective date; and
- You were actively working on the effective date of this Certificate;

We credit any time covered under the prior plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your dependent voluntary term life insurance benefit under this Certificate if it is more than the benefit for which Your dependents were insured under the prior plan. In this case, We limit the benefit to the amount Your dependents would have been entitled to under the prior plan.

B400.3246

CONVERTING THIS DEPENDENT TERM LIFE INSURANCE

**If A Dependent's
Life Insurance Ends**

Dependent term life insurance ends for all of Your dependents when Your group life insurance eligibility ends. Your group life insurance eligibility ends if:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class; or
- Your group life insurance is continued under the Waiver of Premium Benefit provision; or
- You die.

Dependent term life insurance also ends when You stop being a member of a class of Employees eligible for dependent term life insurance.

If Dependent Life Insurance ends for any of the above reasons any dependent who was insured under this Certificate may apply to convert all or part of the amount for which he or she was insured on the day before insurance ended. Your Employer is responsible for notifying You or Your dependents of any conversion options available.

Your dependent may apply to convert up to the full amount of voluntary life insurance for which he or she was insured under this Certificate on the date his or her insurance ended to a permanent life insurance policy.

**If This Certificate
Ends Or Group Life
Insurance Is
Discontinued**

Dependent term life insurance also ends for all of Your dependents:

- If this Certificate ends; or
- Dependent life insurance is discontinued from this Certificate for all Employees or for Your class.

If Dependent term life insurance ends for either of these reasons, and any of Your dependents have been insured by a Guardian Group plan, or a group plan it replaces, for at least five consecutive years, each such dependent may apply to convert to a permanent life insurance policy.

However the amount that he or she can convert in either scenario is limited to the lesser of:

- \$2,000; or
- The amount of Your dependent's life insurance under this Certificate, less any group life insurance for which Your dependent becomes eligible in the 31 days after dependent life insurance under this Certificate ends.

**If A Dependent
Stops Being Eligible**

A dependent's term life insurance ends when he or she stops being an eligible dependent. A Spouse is no longer an eligible dependent when:

- A marriage is lawfully terminated; or

- He or she reaches age 70.

A child is no longer an eligible dependent when he or she reaches the limiting age.

If a dependent stops being eligible, he or she may convert all or part of the amount for which he or she was insured on the day before insurance ended to a permanent life insurance policy.

B401.1965

All Options

How And When to Convert To obtain a Converted Policy, We must receive a written application fully completed by You or Your dependent, and all required premiums within the Conversion Period. Your Employer is responsible for providing You and Your dependents with written Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. You will have 31 days after Your dependent group voluntary life insurance ends to convert. We will not ask for proof that he or she is insurable. If the dependent is a minor or incompetent, the person who cares for and supports the dependent may apply for him or her.

Death During The Conversion Period We will pay a death benefit equal to the amount of dependent life insurance that could have been converted if:

- Your dependent dies within the Conversion Period; and
- But for his or her death, Your dependent would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to you. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You or Your dependent designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.3501

CLAIM PROVISIONS

Your right to make a claim for Group Term Life insurance benefits provided by this Certificate is governed as follows:

Administration We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits under this Plan.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.
- Consider and interpret the terms of this Plan and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Plan and applicable California state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice of Claim Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss You must send written Proof of Loss to Our designated office within 90 days of the loss.

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Life Claims Department

P.O. Box 981573
El Paso, TX 79998-1573

Payment Of Benefits Subject to all the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss. This should be sent to Us as soon as possible. We will pay this benefit in a lump sum.

Interest will be paid on the proceeds if not paid within 30 days of the death of the Insured. Interest will be computed daily at the rate of interest currently payable on individual life policy dividends left on deposit. Such amount shall be added to the life insurance benefit amount.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B401.2794

All Options

DEFINITIONS

This section defines certain terms appearing in this Certificate.

B400.3503

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.3504

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.3506

All Options

Conversion Period This term means the consecutive 31 day period beginning on the date Your Employee and dependent group voluntary life insurance ends.

B400.3510

All Options

Converted Policy This term means a policy which provides individual life insurance, on an interim term or permanent basis, resulting from the option to convert provided in the Policy. The Converted Policy will not provide any:

- Benefits for accidental death;
- Waiver of Premium Benefits; or
- Other supplemental benefits.

The benefits provided by the Converted Policy may not be the same as the benefits provided by this Certificate.

The premium for the Converted Policy will be based on

- Your risk and rate class under this Certificate; and
- Your age on the date the Converted Policy goes into effect.

B400.3513

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.3514

All Options

Disabled This term means the Covered Person is:

- Not able to perform any work for wage or profit; and
- Receiving Regular and Appropriate Care for the cause of Disability.

B400.3516

All Options

Doctor Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.3517

All Options

Domestic Partner This term means Your domestic partner who is registered with the California Secretary of State.

B401.1950

All Options

Effective Date This term means the date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.3518

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.

- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire or the first date after the end of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:

- The Employee's date of hire;
- The first date after any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.3519

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as employees if the Conditions of Eligibility requirements are met.

B400.3521

All Options

Employer This term means HILTON WATERFRONT BEACH RESORT .

B400.3522

All Options

Enrollment Period This term means the 31 day period which starts on the date the Covered Person first becomes eligible for coverage.

B400.3523

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the 6 months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B400.3525

All Options

Initial Dependents This term means those eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your Initial Dependents.

B400.3526

All Options

Newly Acquired Dependent This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B400.3538

All Options

Notice of Right to Convert This term means the written notice presented to You by the Employer, delivered to Your last known address.

B400.3539

All Options

Policy or Plan This term means the Group Term Life insurance coverage described in the Policy and this Certificate.

B400.3541

All Options

Proof Of Insurability This term means the completion of an evidence of insurability requirement as defined in the Schedule of Benefits.

B400.3542

All Options

Proof of Loss This term means the documents that We use to substantiate a claim. Examples of documents used for Proof of Loss include:

- An original certified finalized death certificate;

- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B401.1951

All Options

Reasonable Accommodation This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

B400.3545

All Options

Regular and Appropriate Care This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as recommended by a Doctor to effectively manage these conditions; and
- Are receiving appropriate treatment designed to achieve maximum medical improvement in these conditions.

Appropriate treatment is that treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals, and such treatment must be provided by a Doctor or Doctors whose specialty is appropriate for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Regular and Appropriate Care does not require treatment for a disabling condition where no additional medical treatment will likely cure or improve that condition, and You have achieved maximum medical improvement.

B401.1952

All Options

Spouse This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include Your Domestic Partner.

B401.1953

All Options

Total Disability and Totally Disabled This term means that, due to sickness or injury, the Covered Person is:

- Not able during the first 24 months of claimed Total Disability to perform all the material duties of his or her occupation with Reasonable Accommodation, and after 24 months he or she is not able to perform any occupation for which he or she is reasonably fitted by education, training or experience.

B401.1954

All Options

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

B400.3550

All Options

You or Your These terms mean the insured Employee.

B400.3551

All Options

GROUP TERM LIFE SCHEDULE OF BENEFITS

B400.4199

All Options

Employee Voluntary Term Life Insurance Schedule

B400.4492

All Options

Initial Election You may choose to be insured under one of the plans of Voluntary Term Life Insurance shown below. You may only be insured under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B400.4496

All Options

Changing Election You may switch to another plan of Voluntary Term Life Insurance during the Voluntary life enrollment period. Each year, the Voluntary life enrollment period starts on August 1st and ends on August 31st. You must notify the Employer of any desired switch. We may require Proof Of Insurability before You become insured under the new plan of benefits. See below For details. If We do not require Proof, You will become insured under the new plan of benefits as of the September 1st which coincides with or next follows the end of the Voluntary life enrollment period.

B400.4495

All Options

Voluntary Term Life Insurance Amount *Plan A*

The insurance amount is \$25,000.00

B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan B*

The insurance amount is \$50,000.00

B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan C*

The insurance amount is \$75,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan D*

The insurance amount is \$100,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan E*

The insurance amount is \$125,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan F*

The insurance amount is \$150,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan G*

The insurance amount is \$175,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan H*

The insurance amount is \$200,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan I*

The insurance amount is \$250,000.00
B400.4497

All Options

Voluntary Term Life Insurance Amount *Plan J*

The insurance amount is \$300,000.00

B400.4497

All Options

Annual Election After You first enroll for Employee Voluntary Term Life Insurance, You may choose to increase Your amount of Voluntary Term Life Insurance by an amount not to exceed an increase of \$50,000 as shown above. This option is available once annually during the Voluntary life enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Term Life Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.4698

All Options

Family Status Change You may request a change to your Voluntary Term Life Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Voluntary Term Life Insurance amount or the addition of Employee voluntary term life for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Voluntary Term Life Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Voluntary Term Life Insurance in writing within 31 days after the date of the Family Status Change as described below.

Proof Of Insurability is not required for the change to Voluntary Term Life Insurance due to Family Status Change as long as the change to Your Voluntary Term Life Insurance does not exceed the Proof of Insurability requirements as shown in the Schedule of Benefits. Refer to When Coverage Begins and When Dependent Coverage Begins in the Eligibility section of Your Certificate for information regarding when this coverage is effective.

B400.3558

All Options

Reduction of Voluntary Life Insurance Amount Based on Age

If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

B400.4734

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, You may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the coverage requires an applicant to submit Proof of Insurability, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicants:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to an Applicants driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any condition that must be satisfied for coverage to begin, including but not limited to the requirement that the applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and

Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof of Insurability requirements apply to Voluntary Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof of Insurability in writing before the insurance, or the specified amount of insurance becomes effective.

We require Proof of Insurability as follows:

B400.4903

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.4906

All Options

We require Proof of Insurability before You switch from Your current plan of Voluntary Term Life Insurance to a plan which provides greater benefits.

B400.4909

All Options

We require proof for any amount of Optional Term Life Insurance, which, when combined with the amount for which the employee is insured under his or her GIAC Group Flexible Adjustable Life Insurance Certificate, exceeds \$200,000.00

We require proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent spouse, which, when combined with the amount for which the spouse is insured under the Spouse Term Life Rider to the employee's GIAC Group Flexible Adjustable Life Insurance Certificate, exceeds \$25,000.00.

We require proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent child, which, when combined with the amount for which the child is insured under the Child Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$10,000.00.

GC-SCH-LIFE-15-CA

B400.4912-R

All Options

We require proof for any amount of Optional Term Life Insurance, which, when combined with the amount for which the employee is insured under his or her GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$10,000.00, if the employee's scheduled Optional Term Life effective date is after he or she reaches age 65.

We require proof for any amount of Dependent Optional Term Life Insurance, with respect to a dependent spouse, which, when combined with the amount for which the spouse is insured under the Spouse Term Life Rider to the employee's GIAC Group Flexible Premium Adjustable Life Insurance Certificate, exceeds \$5,000.00, if the dependent spouse's scheduled Optional Term Life effective date is after he or she reaches age 65.

GC-SCH-LIFE-15-CA

B400.4915-R

All Options

We require Proof for all amounts of Voluntary Term Life Insurance, If Your scheduled Voluntary term life effective date is after You reach Age 70.

B400.4917

All Options

Dependent Voluntary Term Life Insurance Schedule

B400.5473

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Term Life Insurance and the plan of dependent child Voluntary life insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.5476

All Options

Voluntary Plan A
Dependent Spouse
Term Life Insurance An amount equal to 50% of Your voluntary term life insurance amount, to a
Amount maximum of \$150,000.00.

B400.5553

All Options

Voluntary Plan A
Dependent Child
Insurance Amount **Child's Age At Death** **Insurance Amount**
From birth but less than 14 days \$500.00
At least 14 days but less than
26 years 10% of Your Voluntary Term
Life amount, to a maximum of \$10,000.00

B400.6727

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B400.6652

All Options

In no event may the insurance amount of a dependent child exceed 10% of Your insurance amount.

B400.6653

All Options

Reduction of
Dependent An employee's dependent benefits are reduced in the same manner as his
Voluntary Life or her employee benefits. The dependent reductions are based on the
Insurance Amount employee's age.
Based on Age

B400.5474

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.6014

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.6018

All Options

A dependent is not covered by any part of this Policy that requires such proof until You give Us this proof and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependents will not be covered by this Policy again until You give Us new proof that they are insurable and We approve that proof in writing.

B400.6019

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6048

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Term Life Insurance with respect to a dependent Spouse.

B400.6049

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance in excess of \$25,000.00 with respect to a dependent Spouse.

B400.6051

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance in excess of \$5,000.00 with respect to a dependent Spouse, if the dependent Spouse's scheduled dependent Voluntary term life effective date is after he or she reaches age 65.

B400.6050

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6060

All Options

We require Proof of Insurability for any increase in the amount of dependent Voluntary Term Life Insurance with respect to a dependent child.

B400.6061

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance in excess of \$10,000.00 with respect to a dependent child.

B400.6062

All Options

Changes to Insurance

B400.6066

All Options

Changes In Insurance Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.6069

All Options

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.6072

SUPPLEMENTAL RIDER - Accelerated Life Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Note: This benefit is not available for retirees.

Employee Accelerated Voluntary Life Benefit

IMPORTANT NOTICE: USE OF THIS BENEFIT MAY HAVE TAX IMPLICATIONS. IT MAY ALSO AFFECT GOVERNMENT BENEFITS OR CLAIMS OF CREDITORS. YOU SHOULD CONSULT YOUR TAX OR FINANCIAL ADVISOR BEFORE YOU APPLY FOR THIS BENEFIT.

THE AMOUNT OF YOUR GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT.

Accelerated Life Benefit You may be eligible for an Accelerated Life Benefit if you meet the following conditions:

- You have a Terminal Condition;
- You supply the required written proof of Your Terminal Condition (see "Notice of Claim");
- You apply for this benefit in writing while living and before You attain age 60. If You are unable to request this benefit yourself, Your legal representative may request it on Your behalf.

This benefit is a payment of part of Your Group Term Life Insurance made to You before death. You may use this benefit in any way You choose, subject to the restrictions stated below.

If You qualify for the Accelerated Life Benefit, We will subtract the Gross Amount paid to You as an Accelerated Life Benefit from the amount of Your Group Term Life Insurance under the Certificate. The remaining amount of Group Term Life Insurance is permanently reduced by the Gross Amount of this benefit.

You may only receive one Employee Accelerated Life Benefit during Your lifetime. This benefit does not have to be repaid, even if You:

- Live longer than 12 months from the date We receive Your request for this benefit; or
- Recover from the Terminal Condition.

However, the amount of this benefit will not be restored to Your remaining Group Term Life Insurance. And, You may not receive another Accelerated Life Benefit under any circumstances and even if You:

- Have a relapse; or

- You are subsequently diagnosed as having another Terminal Condition.

Benefit Amount For The Accelerated Life Benefit The amount of the Accelerated Life Benefit for which You may apply is based on the amount of group term life insurance for which You are insured on the day before You apply for the benefit subject to the following minimum and maximum amounts.

The minimum benefit amount is the lesser of: (1) \$10,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) \$250,000.00; or (2) 50% of Your amount of Group Term Life Insurance.

Discount The amount of the Accelerated Life Benefit which is available to You is discounted to the present value in 12 months from the date this benefit is paid. The discount is based on the maximum adjustable policy loan interest rate permitted in the state in which the group policy is delivered.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is available from Us on request.

Payment Of The Accelerated Life Benefit If We approve Your request for this benefit, We pay the amount You have elected, less the present value discount. We pay this benefit to You in one lump sum. This payment is subject to all of the other terms of the Certificate.

Notice of Claim You must send Us a request which includes written proof from a Doctor who is operating within the scope of his or her license that You have a Terminal Condition. We must approve such proof in writing before this benefit is paid.

Physical Examinations

We may have You examined by a Doctor of Our choice to determine whether the Terminal Condition exists. We will pay the cost of such exam.

If We approve Your request to receive this benefit, We will provide You with a statement along with Your benefit payment which shows:

- The amount of the Accelerated Life Benefit You requested;
- The amount of the present value discount;
- The amount of Your Accelerated Life Benefit check; and
- The remaining amount of Your Voluntary Life Insurance coverage.

Even if You have been approved for a waiver of premium benefit under this Certificate, You may still apply for an Accelerated Life Benefit. But, if You convert Your Group Term Life Insurance, the terms of the converted life policy will apply. Any amount to which You could otherwise convert is permanently reduced by the gross amount of Your Accelerated Life Benefit.

If You Have Assigned Your Group Term Life Insurance If You have already assigned Your Group Term Life Insurance, or any portion thereof, You cannot apply for an Accelerated Life Benefit.

If You Are Legally Incompetent If You are not legally competent, Your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs may apply for the Accelerated Life Benefit on Your behalf.

Your Remaining Group Term Life Insurance The remaining amount of Your Group Term Life Insurance after You receive an Accelerated Life Benefit payment is subject to any increases or reductions that would otherwise apply to Your insurance. Applicable reductions are applied to the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

If Your Life Benefit is scheduled to reduce within 12 months of the date You apply for the Accelerated Life Benefit, any applicable reduction will also be applied to Your Accelerated Benefit amount.

The premium cost of Your remaining insurance is based on the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

The total amount of Group Term Life Insurance Your beneficiary would otherwise receive on Your death is reduced by the Gross Amount of the Accelerated Life Benefit.

If You die after applying, and were eligible, for the Accelerated Life Benefit, but before We send You the benefit, Your beneficiary will receive the full amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

Restrictions We will not pay an Accelerated Life Benefit if:

- Your coverage under the Certificate ends for any reason after You apply for the Accelerated Life Benefit, but before We pay such benefit;
- You are required by law to use the proceeds of the Group Term Life Insurance from the Certificate to meet the claims of creditors, whether or not You are in bankruptcy;
- You are required by court order to pay all or part of the proceeds of the Group Term Life Insurance from the Certificate to another person; or
- You are required by a government agency to use the payment to apply for, receive or maintain a governmental benefit or entitlement.

Definitions This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Doctor:** Any medical practitioner We are required by law to recognize. He or she must:
 - Be properly licensed or certified by the laws of the state where he or she practices; and
 - Provide services that are within the lawful scope of his or her practice.
- **Gross Amount:** This term means the amount of the Accelerated Life Benefit elected by You before subtraction of the discount.

- **Group Term Life Insurance:** This term means the amount of Employee Voluntary Group Term Life Insurance for which You are insured under the Certificate. The term does not include any:
 - Accidental death benefits; or
 - Scheduled increase in the amount of Employee Voluntary group term life insurance that is due within the 12 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is reasonably expected to result in death within 12 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Michael Estep", with a stylized flourish at the end.

Michael Estep, Vice President

B401.1995

SUPPLEMENTAL RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

**Employee Voluntary Term Life Insurance and
Dependent Voluntary Term Life Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Voluntary term life insurance and dependent Voluntary term life insurance.

Seatbelt And Airbag Benefits If You die as a direct result of an automobile accident while properly wearing a seatbelt, We will increase Your term life benefit amount by \$10,000. And, if You die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your term life benefit amount by an additional \$5,000, for a total increase of \$15,000.

Notice of Claim: You must send Us a request which includes written proof that You were properly wearing a seatbelt. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits. We must approve such proof in writing before this benefit is paid.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your term life benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Voluntary term life insurance and Basic Accidental Death and Dismemberment insurance may not exceed \$30,000.

Late Notice and Proof of Loss: We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Group Life Claims Department
P.O. Box 981573

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While You are legally intoxicated; or
- While You are voluntarily using a controlled substance, unless:
 - It was prescribed for You by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits If Your dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, We will increase his or her Voluntary term life benefit amount by \$5,000. And, if Your dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase his or her Voluntary term life benefit amount by an additional \$2,500, for a total increase of \$7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile accident directly resulting in his or her death, We will increase Your dependent term life benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While Your dependent is legally intoxicated; or
- While Your dependent is voluntarily using a controlled substance, unless:
 - It was prescribed for the dependent by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Michael Estep", with a stylized flourish at the end.

Michael Estep, Vice President

B401.2060

SUPPLEMENTAL RIDER - Waiver of Premium Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

**Employee Voluntary Term Life Insurance
Waiver Of Premium Benefit**

Important Notice This rider applies to Your Voluntary term life insurance. It does not apply to any of Your dependent life insurance under the Certificate. To continue dependent life insurance, You must convert Your dependent coverage. See "Converting This Dependent Term Life Insurance" for details.

If You Are Disabled If You are Totally Disabled, and meet the requirements in "How And When To Apply," We will extend Your Voluntary life insurance without payment of premiums from You or the Employer in an amount equal to the amount of Voluntary life insurance for which You are insured on Your last day of Active Work.

How And When To Apply To apply for this benefit, You must submit, while living, written medical proof of Your Total Disability satisfactory to Us within one year of the start of that disability. Any claim filed after one year from the start of Total Disability will be denied, unless We receive written proof that:

- You lacked the legal capacity to file the claim; or
- It was not reasonably possible for You to file the claim within the required period of time.

To be approved for this benefit, You must:

- Become Totally Disabled before You reach age 60 and while insured by the Certificate; and
- Remain Totally Disabled for at least 9 months in a row.

You should apply for this benefit immediately at the start of Your Total Disability.

Continued Proof For Waiver of Premium Benefit We may require written proof that You remain Totally Disabled and receive regular Doctor's care to maintain this benefit. This proof must be given to Us within 30 days of the date We request it.

We can also require that You take part in a medical assessment by a medical professional of Our choice as often as We feel is reasonably necessary during the first 2 years We have waived Your life insurance premiums pursuant to the Rider. After 2 years, We cannot have You examined more than once a year.

Until You Have Been Approved For This Benefit If Your life insurance under the Certificate ends after You have become Totally Disabled and applied for Waiver of Premium Benefits, but before We have approved You for this benefit, You may:

- Continue to pay your group premium payments, including any part which would have been paid by the Employer, until You are approved or declined for this benefit; or
- Apply to convert to an individual permanent or term life insurance policy.

Please read "Converting This Employee Voluntary Term Life Insurance" for details on how to convert.

Converting Your life insurance does not stop You from claiming Your rights under this section. But, if You apply to convert and obtain a policy, and We later approve You for this benefit, We will cancel the converted policy on the date We approve You for this Benefit. See "Converting This Employee Voluntary Term Life Insurance" for details on how We do this. Once You are approved for this benefit, Your insurance under the Certificate will be reinstated at no further cost to You or the Employer.

If You are declined for the Waiver of Premium benefit, You will have the option to apply to convert to an individual permanent or term life insurance policy. If You do not convert within 31 days of the date You are declined for the Waiver of Premium benefit, and You have not returned to Active Work, Your coverage will end.

If the Certificate terminates before You are approved

If this group Certificate terminates and You are Totally Disabled and eligible, but not yet approved, for this Waiver of Premium benefit, You must apply to convert to an individual permanent or term policy, and remain insured under such policy until You are approved by Us for the Waiver of Premium benefit.

When This Waiver Begins

Once approved by Us, Your Waiver of Premium benefit will be effective on the date following the day You have been Totally Disabled for 9 months in a row.

When This Waiver Ends

Your Waiver of Premium benefit will end on the earliest of:

- The date You are no longer Totally Disabled;
- The date We ask You to be examined by Our Doctor, and You refuse;
- The date You do not give Us the proof of Total Disability We require;
- the date you have been out of the United States and/or Canada or a country or region approved by Us for more than 2 months in a 12 month period;
- The date You are no longer receiving regular Doctor's care appropriate to the cause of Your claimed Total Disability;
- The day before the date You reach age 65.

If Your Waiver of Premium Benefit ends and You do not return to Active Work, You will have the option to convert the Employee Voluntary life insurance that was in effect on the date the Waiver of Premium Benefit ends.

Please read "Converting This Employee Voluntary Term Life Insurance" for details on how to convert.

If You Die While Covered By This Waiver of Premium Benefit

If You die while covered for this benefit, We will pay Your beneficiary the amount of Voluntary life insurance for which You were insured as of Your last day of Active Full-Time Work. This payment is subject to all the terms of the Certificate and all reductions which would have applied had You remained an Active at Work Employee.

If You Die Prior to Approval for This Waiver of Premium Benefit

If You die prior to being approved for the Waiver of Premium Benefit and within 12 months of the onset date of Total Disability We'll pay Your beneficiary the amount for which You were covered as of Your last day of Active Full-Time Work, subject to all reductions which would have applied had You stayed an active Employee provided You:

- Were Totally Disabled, as defined by this Rider, through the date of death,
- Became Totally Disabled prior to age 60; and
- Became Totally Disabled while insured; and
- We received the required premiums for this coverage.

Proof Of Death

We will pay the term life insurance benefit as soon as We receive:

- Written proof of Your death; and
- Medical proof that You were continuously Totally Disabled until Your death.

This proof must be sent to Us within one year of Your date of death.

B400.3854

All Options

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as recommended by a Doctor to effectively manage these conditions; and
- Are receiving appropriate treatment designed to achieve maximum medical improvement in these conditions.

Appropriate treatment is that treatment a patient would make a reasonable decision to accept after duly considering the options of medical professionals, and such treatment must be provided by a Doctor or Doctors whose specialty is appropriate for You:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Regular and Appropriate Care does not require treatment for a disabling condition where no additional medical treatment will likely cure or improve that condition and You have achieved maximum medical improvement.

"Total Disability" and "Totally Disabled": This term means that, due to sickness or injury, You are:

- Not able during the first 24 months of Your claimed Total Disability to perform all the major duties of Your occupation with Reasonable Accommodation, and after 24 months You are not able to perform any occupation for which You are reasonably fitted by education, training or experience.

This Rider is a part of this Certificate. 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



Michael Estep, Vice President

B401.2005

SUPPLEMENTAL RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

PORTABILITY PRIVILEGE

This rider applies only to Your Employee and dependent Voluntary term life insurance.

**Portability
Conditions**

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
 - You are no longer employed by the Employer; or
 - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Voluntary term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
 - Failure to pay any required premium; or
 - Termination of the Certificate

Portability Options

You may Port the full amount of Your Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least \$50,000 and does not exceed \$1,000,000.

You may Port the full amount of Your dependent's Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount if:

- Your dependent Spouse amount under the Certificate is at least \$10,000; and
- Your dependent child amount under the Certificate is at least \$2,000.

You may Port:

- Your insurance only;
- Your insurance and insurance of Your covered Spouse; or
- Your insurance and the insurance of all of Your covered dependents.

If You Port the full amount of Your insurance and You choose to Port Your dependent's insurance, You must Port the full amount of Your dependent's insurance. If You Port 50% of Your insurance and You choose to Port Your dependent's insurance, You must Port 50% of Your dependent's insurance.

A dependent must be insured as of the date Your coverage under the Certificate ends in order to be eligible for Portability.

If You die while insured for dependent Voluntary term life insurance, Your Spouse may Port Your dependent Voluntary term life insurance as described above. Your Spouse and dependent children must be insured under the Certificate on the date of Your death. But, this option is not available if:

- There is no surviving Spouse; or
- Your surviving Spouse has reached age 70 on the date of Your death.

The Portable Certificate Of Coverage

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees and their dependents whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your or Your surviving Spouse's age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port You or Your surviving Spouse must:

- Apply to Us in writing; and
- Pay the required premium.

You or Your surviving Spouse must do this within 31 days from the date Your coverage under the Certificate ends. In order to port Your Voluntary term life insurance, We will not ask for proof that You or Your surviving Spouse is insurable.

Portability And Conversion If You or Your surviving Spouse choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You or Your surviving Spouse should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port":**these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

This rider is a part of this Certificate. 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

A handwritten signature in black ink, appearing to read "Michael Estep", is positioned above the printed name.

Michael Estep, Vice President

B400.3884

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

This Rider amends the Certificate by replacing the definition of **Spouse** and **Domestic Partner** with the following:

Spouse: This is the person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: This is the same-sex or opposite-sex person with whom Your domestic partnership is currently registered with any state or local government domestic partner registry.

This term includes an unregistered Domestic Partner, who is the person with whom You live and share financial assets and obligations. An unregistered Domestic Partner must be at least 18 years of age, able to provide legal consent and cannot be a blood relative. You and Your unregistered Domestic Partner may not be married to, in a marriage or domestic partnership with, or legally separated from anyone else.

Domestic Partners are not subject to any proof of relationship or waiting period requirements not also imposed upon marriages. A Domestic Partner registry certificate will be accepted as fully equivalent to a marriage certificate.

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

B601.0173

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term life insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Life Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with the authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has the authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

Timing for Initial Benefit Determination of Life Insurance Claims

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

**Adverse Benefit
Determination of
Life Insurance
Claims**

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures; and
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination.

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All Options

**Appeals of Adverse
Determinations of
Life Insurance
Claims**

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits; and
- Provide a statement describing any voluntary appeal procedures offered by the Plan, the claimant's right to obtain information about such procedures, and a statement that the claimant's right to bring an action under ERISA section 502(a).

Waiver of Premium If you apply for an extension of life insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination

If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0240

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0241

This Booklet Includes All Benefits For Which You Are Eligible.

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

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

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

The Group Accidental Death and Dismemberment Coverage described in this Certificate is attached to the group Policy effective September 1, 2007. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) satisfy any necessary Proof of Insurability requirements; and all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

FOR INSURED PERSONS AGE 65 OR OLDER WHO PAY SOME OF ALL OF THE COST OF THIS INSURANCE: YOU HAVE A 30 DAY EXAMINATION PERIOD AFTER THE RECEIPT OF THIS CERTIFICATE DURING WHICH YOU MAY CANCEL THE COVERAGE AND RETURN THIS CERTIFICATE BY MAIL OR OTHER DELIVERY METHOD. SUCH RETURN WILL VOID THE CERTIFICATE FROM THE BEGINNING, AND THE PARTIES WILL BE IN THE SAME POSITION AS IF A CERTIFICATE HAD NOT BEEN ISSUED. ALL PREMIUMS PAID WILL BE FULLY REFUNDED IN A TIMELY MANNER NOT LATER THAN 30 DAYS AFTER THE COMPANY RECEIVES THE RETURNED CERTIFICATE.

Policyholder: HILTON WATERFRONT BEACH RESORT
Group Policy Number: 00429264

The Guardian Life Insurance Company of America



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Estep, Vice President

B401.2172

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COMPLAINT NOTICE

This notice is to advise You that should any complaints arise regarding this insurance You may contact the Guardian at the following address or phone number:

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, NY 10001
(212) 598-8000

If You feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)
Website: www.insurance.ca.gov/01-consumers/

B401.2173

GENERAL PROVISIONS

The Contract and Limitation Of Authority

The entire contract between the Policyholder and Us consists of:

- The Policy;
- The Schedule of Premium Rates;
- This Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and Your application.

In the event of a conflict, the Policy shall reign.

We can amend the Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by the Policyholder and agreed to by Us; or
- On any date Our obligation under the Policy with respect to the Policyholder, or under this Certificate with respect to You, is changed do to the requirements of state or federal law or regulation.

Upon request, You may obtain a copy of the Policy from Us.

If We amend this Certificate, except upon request made by You, We must give You written notice of such change.

Any amendments to this Certificate will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an enrollment form or other required form; and
- We have received any required premium.

Incontestability

Any statement made by You, in the absence of fraud, will be deemed a representation and not a warranty. No statement will be used to avoid insurance, reduce benefits or defend a claim unless it is material to the risk accepted or the hazard assumed by Us, has been signed by You, and a copy of the statement has been given to You or to Your Beneficiary. We shall not contest this coverage after it has been in force during Your lifetime for three years from the Effective Date of the Policy.

Physical Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under the Certificate as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit, or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.2175

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Accidental Death and Dismemberment coverage if You are

- In an eligible class of Employees;
 - Are an active Full time Employee;
 - Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us;
- and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Accidental Death and Dismemberment coverage if You are

- A temporary or seasonal Employee.

The Waiting Period If You are in an eligible class, You are eligible for Accidental Death and Dismemberment coverage under this Certificate after You complete the service waiting period, if any, established by the Employer and as stated in the Schedule of Benefits.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Accidental Death and Dismemberment Coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.6098

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Your coverage is scheduled to start on Your Eligibility Date.

B400.6105

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date ; and
- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, in no event will any coverage or part of coverage for which You must elect and pay all or part of the cost, start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.6106

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
 - Disability;
 - Death;
 - Retirement;
 - Layoff;
 - Leave of absence;
 - The end of employment; and
 - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
- The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Contact Your Employer regarding any continuation options available.

B400.6110

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date we request it.

Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months following the date the temporary layoff begins.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months following the date the approved leave of absence begins.

If You become disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.6111

**EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT
(AD&D) INSURANCE**

B400.6134

Basic Accidental Death and Dismemberment Insurance

B400.6135

We will pay the benefits described below if You suffer an irreversible loss due to an Accident and the Accident occurs while You are insured by this Certificate. The loss also must:

- Be a result of the Accident; and
- Occur within 365 days of the date of the Accident.

Payment Of Benefits We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

Payment Of Benefits For Covered Loss of life, We pay the beneficiary of Your Accidental Death and Dismemberment Insurance under the Employer's Policy with Us.

For all other Covered Losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your Term Life coverage under the Employer's Plan with Us.

Subject to all the terms of this Certificate, We pay all benefits in a lump sum as soon as We receive written proof of Covered Loss and proof of claim. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

B401.2183

All Options

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

B400.6147

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of Your AD&D insurance amount.
Disappearance	100% of Your AD&D insurance amount.
Loss of a hand	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".

Loss of a foot	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of Your AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

B400.6143

All Options

As used here:

- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.
- "Loss of the great toe (hallux)" means complete severance at the metatarsalphalangeal joint.

B400.6149

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of Your Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of Your Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6151

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to \$5,000 for costs to prepare and transport Your body to a mortuary chosen by You or an authorized agent. In the event that a Repatriation Benefit is paid under Your Group Term Life Insurance Certificate, no additional benefit will be paid under this Accidental Death and Dismemberment Certificate.

B400.6155

All Options

Exposure If You suffer a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss. If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payments.

B400.6156

All Options

Disappearance You will have a presumed Covered Loss due to an Accident if:

- You are riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- Your body is not found within 365 days of the day the Accident; and
- The Accident occurs while You are covered by this Certificate.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payments.

B400.6157

CLAIM PROVISIONS

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits under this Plan.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.
- Consider and interpret the terms of this Plan and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Plan and applicable California state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Notice of Claim: Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss, or as soon thereafter as is reasonably possible. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms: We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of Your legal capacity, later than one year from the time proof is otherwise required.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Group Life Claims Department

P.O. Box 981573

El Paso, TX 79998-1573

Time of Payment of Claim: We will pay the Group Accidental Death & Dismemberment Insurance Benefit immediately upon receipt of written Proof of Loss.

Legal Actions: No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B401.2193

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.7183

All Options

Accident This term means an unexpected event or occurrence, which results in bodily injury or death while a Covered Person is insured by this Certificate. The term Accident does not include a Sickness.

B401.2194

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.7186

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.7188

All Options

Covered Loss This term means loss due to an Accident while a Covered Person is insured by this Certificate and as outlined in the Table of Covered Losses.

B400.7189

All Options

Covered Person This term means the Employee insured by this Certificate.

B400.7191

All Options

Domestic Partner This term means Your domestic partner who is registered with the California Secretary of State.

B401.2196

All Options

Effective Date The date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.7192

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who had completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility date will be the later of:

- The Employee's date of hire;
- The first date following the completion of any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

B400.7194

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

B400.7195

All Options

Employer This term means HILTON WATERFRONT BEACH RESORT .

B400.7196

All Options

Enrollment Period This term means the 31 day period which starts on the date You first become eligible for coverage.

B400.7197

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the six months prior to the last full day worked was at least 30 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B401.3005

All Options

Legally Intoxicated "Intoxicated" means that the Covered Person's blood alcohol content meets or exceeds the percentage or amount of blood alcohol content that creates a legal presumption of intoxication under the laws of the state or territory in which the loss occurred for operating a motor vehicle under the influence, regardless of whether the Covered Person was operating a motor vehicle at the time the loss occurred.

B400.7219

All Options

Month or Months or Monthly These terms mean a consecutive 30 day period.

B400.7220

All Options

Policy or Plan This term means the Group Accidental Death and Dismemberment Coverage described in the Policy and in this Certificate.

B400.7223

All Options

Proof Of Insurability This terms means the completion of an evidence of insurability form, which shows that a person is insurable.

B400.6388

All Options

Proof of Loss This term means the documents that We use to substantiate an accidental death and dismemberment claim. Examples of documents used for Proof of Loss include:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B401.2197

All Options

Spouse This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include Your Domestic Partner.

B401.2198

All Options

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

B400.7229

All Options

You or Your These terms mean the insured Employee.

B400.7230

EXCLUSIONS

Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate.

- Willful self-injury, suicide, or attempted suicide while sane or insane;
- Sickness, disease, mental infirmity, or result of any medical or surgical treatment;
- Infection, except pyogenic infections which result from a bodily injury or bacterial infections which result from the unintentional ingestion of contaminated substances;
- The intentional or voluntary inhalation or ingestion of gas, chemical, solvent, poison or other substances not intended for internal consumption;
- An injury the Covered Person suffers while taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony, as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- Injury suffered while travelling on any type of aircraft if the Covered Person is an instructor or crew member; or has any duties at all on that aircraft;
- Injury suffered in declared or undeclared war or act of war or armed aggression;
- Injury suffered while the Covered Person is a member of any armed force;
- Injury suffered while the Covered Person is Legally Intoxicated; or
- Injury suffered while the Covered Person is voluntarily using a controlled substance, unless:
 - It was prescribed for the Covered Person by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

B401.2787

All Options

**GROUP ACCIDENTAL DEATH AND DISMEMBERMENT
SCHEDULE OF BENEFITS**

B400.7846

All Options

**Employee Basic Accidental Death And Dismemberment (AD&D)
Insurance Schedule**

B400.7859

All Options

Basic AD&D Insurance Amount The Insurance Amount is \$20,000.00
B400.7860

All Options

Reduction of Basic AD&D Insurance Amount Based on Age If You are less than age 65 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 65, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 65, but before You reach age 70.

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.7899

All Options

Proof of Insurability Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Basic Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or
- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

If Your Active Full-Time Work ends before You meet any Proof Of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B400.8032

All Options

Changes to Insurance

B400.9564

All Options

Changes In Insurance Amounts

If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.9567

All Options

Changes In Insurance Classification

If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.9570

CERTIFICATE RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

**Employee Basic Accidental Death
and Dismemberment Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Basic Accidental Death and Dismemberment Insurance.

**Seatbelt And Airbag
Benefits**

If You die as a result of an automobile Accident while properly wearing a seatbelt, We will increase Your Accidental Death and Dismemberment Benefit amount by \$10,000. And, if You die as a result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your Accidental Death and Dismemberment Benefit amount by an additional \$5,000, for a total increase of \$15,000.

Notice of Claim: You must send Us a request which includes written proof that You were properly wearing a seatbelt. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits. We must approve such proof in writing before this benefit is paid.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your Accidental Death and Dismemberment Benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic Accidental Death and Dismemberment Insurance and Basic and Voluntary Group Term Life Insurance and may not exceed \$30,000.

**Late Notice and
Proof of Loss:** We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

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

Exclusions This Certificate Rider does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While You are Legally Intoxicated;
- While You are voluntarily using a controlled substance, unless:
 - It was prescribed for You by a Doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

The Guardian Life Insurance Company of America



Michael Estep, Vice President

B401.2222

CERTIFICATE RIDER

This Rider is effective on the Policy Date. This Rider amends the Certificate by the replacement of the Incontestability provision to the following:

Time Limit On Certain Defenses

After the Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

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

Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read "Michael Estep", with a stylized flourish at the end.

Michael Estep, Vice President

GC-R-TLCD2-19-CA

B439.0017

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

This Rider amends the Certificate by replacing the definition of **Spouse** and **Domestic Partner** with the following:

Spouse: This is the person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: This is the same-sex or opposite-sex person with whom Your domestic partnership is currently registered with any state or local government domestic partner registry.

This term includes an unregistered Domestic Partner, who is the person with whom You live and share financial assets and obligations. An unregistered Domestic Partner must be at least 18 years of age, able to provide legal consent and cannot be a blood relative. You and Your unregistered Domestic Partner may not be married to, in a marriage or domestic partnership with, or legally separated from anyone else.

Domestic Partners are not subject to any proof of relationship or waiting period requirements not also imposed upon marriages. A Domestic Partner registry certificate will be accepted as fully equivalent to a marriage certificate.

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

B601.0173

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

10 Hudson Yards
New York, New York 10001
(212) 598-8000

Your group term accidental death and dismemberment insurance benefits may be covered by the Employee Retirement Income Security Act of 1974 (ERISA). If so, you are entitled to certain rights and protections under ERISA.

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforcement of Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules (see Claims Procedures below).

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Accidental Death and Dismemberment Insurance Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Guardian Life Insurance Company of America (hereinafter referenced as Guardian.)

Guardian is the Claims Fiduciary with the authority to interpret and construe the terms of the Policy, the Certificate, the Schedule of Benefits, and any riders, or other documents or forms that may be attached to the Certificate or the Policy, and any other plan documents. Guardian has the authority to determine eligibility for benefits and coverage under those documents. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

**Timing for Initial
Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

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

Guardian will provide a benefit determination not later than 90 days from the date of receipt of a claim. This period may be extended by up to 90 days if Guardian determines that an extension is necessary due to special circumstances, and so notifies the claimant before the end of the initial 90-day period. Such notification will include the reason for the special circumstances requiring the extension and a date by which the determination is expected to be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision of the claim, and the additional information needed to resolve those issues.

**Adverse Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

If a claim is denied, Guardian will provide notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement, that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0242

All Options

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

If a claim is wholly or partially denied, you will have up to 60 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 60 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 60-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium If you apply for an extension of accidental death and dismemberment insurance benefits due to Total Disability under the Waiver of Premium benefit under this plan, these claim procedures will apply to such request:

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

Guardian will make a determination of whether the claimant meets the plan's standard for total disability not later than 45 days from the date of receipt of a claim. This period may be extended by up to 30 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 45-day period. Such notification will include the reason for the extension and a date by which the determination will be made. If prior to the end of the 30-day period Guardian determines that an additional extension is necessary due to matters beyond the control of the plan, and so notifies the claimant, the time period for making a benefit determination may be extended for up to an additional period of up to 30 days. Such notification will include the special circumstances requiring the extension and a date by which the final determination will be made.

A notification of an extension to the time period in which a benefit determination will be made will include an explanation of the standards upon which entitlement to a benefit is based, any unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit the information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

Adverse Benefit Determination If a claim for an extension of benefits is denied, Guardian will provide a notice that will set forth:

- The specific reason(s) for the adverse determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information needed to perfect the claim, and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0243

All Options

Appeals of Adverse Determinations for Waiver of Premium

If a claim for Waiver of Premium is denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- The opportunity to submit written comments, documents, records and other information relating to the claim;
- The opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relevant to the claim; and
- A review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;

- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- Ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision not later than 45 days after receipt of the request for review of the adverse determination. This period may be extended by an additional period of up to 45 days if Guardian determines that special circumstances require an extension of the time period for processing and so notifies the claimant before the end of the initial 45-day period.

A notification with respect to an extension will indicate the special circumstances requiring an extension of the time period for review, and the date by which the final determination will be made.

In the event Guardian denies the appeal of an adverse benefit determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;

- Provide a statement describing the claimant's right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;
- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

In addition to any legal rights you may have under section 502(a), if you believe that we have violated ERISA's procedural requirements, you may request that we review any claimed violation(s) and we will respond to you within ten days.

B997.0244

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

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

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

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

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

To register, go to www.GuardianAnytime.com



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