YOUR GROUP INSURANCE PLAN BENEFITS

RIO VISTA DEVELOPMENT COMPANY
CLASS 0001
AD&D, 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.

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

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

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/

CGP-3-CADISC-91 B120.0090

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

All Options

Incontestability

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

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

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

CGP-3-R-INCY-96 B160.0061

All Options

Examination and Autopsy

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

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

All Options

Accident and Health Claims Provisions

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

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

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

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

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

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

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

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

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

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

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.

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.

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.

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.

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.

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 AND DISMEMBERMENT COVERAGES

B264.0003

All Options

Employee Coverage

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

Other Conditions You must:

(a) be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

(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.

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.

CGP-3-EC-90-1.0 B264.2327

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

Exception to When Your Coverage Starts

If you are not capable of performing the major duties of your regular occupation for the employer on a full-time basis on the date your coverage is scheduled to start, you will be insured for Life insurance if:

1. you were insured under the prior insurer's group Life policy at the time of the transfer;
2. you were a member of an eligible class under the prior carrier's group life policy and are eligible under this plan;
3. your premiums for the employee were paid up to date;
4. your premiums are not currently being waived under the Extended Life Benefit provision, or you were not eligible, under the terms of the prior insurer's group Life policy, to have premiums waived under the Extended Life Benefit provisions; and
5. you are not receiving or eligible to receive benefits under the prior carriers group Life policy.

Any Life benefit payable will be the lesser of:

1. the Life benefit payable under the Group Policy; or

2. the Life benefit payable under the prior insurer's group Life policy had it remained in force.

The Life benefit payable will be reduced by any amount paid by the prior insurer's group life policy.

An employee covered under the Exception to When Your Coverage Starts will not be eligible for (1) Extended Life Benefit provision under this Policy; or (2) Accidental Death and Dismemberment coverage, if any, until such a time that you are Actively At Work as defined by this policy.

All other provisions under this Policy, including Accelerated Life Benefit, Conversion and Dependent coverage, if any, will apply under the Exception to Your Coverage Starts.

You will remain insured under this provision until the first to occur of: 1) the date you are fully capable of performing the major duties of your occupation for the employer on a Full-Time basis; 2) the date insurance terminates for one of the reasons stated in When Your Coverage Ends; 3) the last day of a period of 12 consecutive months which begins on the Policy effective date; 4) the date you become eligible for the Extended Life Benefit provision under the prior insurer's group Life policy; or 5) the last day the you would have been covered under the prior insurer's group Life policy, had the prior plan not been terminated.

CGP-3-EC-90-2.0 B264.3167

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, or working outside of the United States for a United States based employer in a country or region approved by us.

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 B264.2385

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 and Accidental Death and Dismemberment 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.

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 $15,000.00

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 insurance amount is reduced, when he or she reaches age 70, by 60% 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 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% 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 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% 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 80.

CGP-3-R-SCH-90 B265.0485

All Options

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90 B265.0029

All Options

Your Basic AD&D Insurance Amount

Insurance Amount $15,000.00

CGP-3-R-SCH-90 B265.0031

All Options

Reduction of Basic AD&D 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 insurance amount is reduced, when he or she reaches age 70, by 60% 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 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% 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 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% 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 80.

CGP-3-R-SCH-90 B265.0496

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.

All Options

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

All Options

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

All Options

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.

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.

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.

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.

Your Basic Accidental Death And Dismemberment Benefits

The Benefit

We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 365 days of the date of the accident.

Covered Losses

Benefits will be paid only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

(a) a hand or foot means it is completely cut off at or above the wrist or ankle.

(b) sight means the total and permanent loss of sight.

Payment Of Benefits

For covered loss of life, we pay the beneficiary of your basic group term life insurance.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary of your basic group term life insurance.

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

CGP-3-R-ADCL1-00 B310.1138

All Options

Exclusions

We won't pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) 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.

CGP-3-R-ADCL2-00 B310.1049

Option A

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Option A

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 A

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 A

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 A

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 A

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

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

Definitions

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

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

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

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 A

Dependent Coverage

B200.0271

Option A

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 A

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 A

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 A

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 A

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 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 B489.0254

Option A

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 A

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 A

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

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

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

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent.* This happens to a child 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

Option A

CERTIFICATE AMENDMENT

Effective January 1, 2017, 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 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.

Your registered domestic partner will be eligible for dental coverage under this plan.

A 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.

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.

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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

Option A

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 A

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

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

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

  For Group I Services 80%
  For Group II Services 70%
  For Group III Services 40%

CGP-3-DENT-HL-90 B497.0088

Option A

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

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

CGP-3-DENT-HL-90 B497.0104

Option A

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 A

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 A

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 A

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. 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.

Option A

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. In the case of a composite filling on a *posterior tooth*, the benefit will be based on the corresponding amalgam filling benefit.

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.

Option A

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.*

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 B498.0004

Option A

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 A

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

Option A

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.

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 B498.0232

Option A

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 A

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,500.00.

CGP-3-DGY2K-BP B498.0192

Option A

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 A

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* 80%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 70%
- Benefits for Group III Services performed by a *preferred provider* 50%
- Benefits for Group III Services performed by a *non-preferred provider* 40%

CGP-3-DGY2K-PR B498.0078

Option A

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.

CGP-3-DGY2K-END B498.0234

Option A

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Option A

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 A

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.

Option A

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, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.

- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.

- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

- Any restoration, procedure, *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, including but not limited to nitrous oxide, except 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, including traditional photographs and images obtained by intraoral camera, except 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* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis;* unless (1) it is at least 5 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't 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 Worker's 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.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*

CGP-3-DGY2K-EXCH B498.2127

Option A

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 three 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.

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 B490.0148

Option A

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 *covered persons* under age 19 and 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.

Option A

Radiographs

Allowance includes evaluation and diagnosis.
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.

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

Other diagnostic radiographs:

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

Intraoral periapical or occlusal films - single films

Option A

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 A

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

Restorative Services Multiple restorations on one surface will be considered one restoration. 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 - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

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

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

CGP-3-DNTL-90-15 B498.2780

Option A

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.

Option A

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
- Pulp capping, direct
- Pulp capping, indirect - includes sedative filling.

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

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only

Root Canal Treatment
- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

Other Endodontic Services
- Apexification, limited to a maximum of three visits
- Apicoectomy, limited to once per root, per lifetime
- Root amputation, limited to once per root, per lifetime
- Retrograde filling, limited to once per root, per lifetime
- Hemisection, including any root removal, once per tooth

CGP-3-DNTL-90-15.0 B498.0201

Option A

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 A

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

Option A

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.

Option A

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 A

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. Post and cores are covered only when needed due to decay or *injury.* Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

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

Inlays
Onlays, including inlay
Labial veneers
Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth
- Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth
- Crown or core buildup, including pins

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment
- Custom abutment

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

Surgical placement of implant body, endosteal implant
Surgical placement, eposteal implant
Surgical placement transosteal implant

Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime
Radiographic/surgical implant index - limited to once per arch in any 24 month period
Repair implant supported prosthesis
Repair implant abutment
Implant removal

Option A

Prosthodontic Services

Specialized techniques and characterizations are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only.

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

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

All Options

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B505.0152

All Options

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 December 1st to December 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

All Options

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 that 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,* 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 within 31 days of your *eligibility date,* date, your dependent coverage is scheduled to start on 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 B505.0714

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.

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 January 1, 2017, 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 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.

Your registered domestic partner will be eligible for vision coverage under this plan.

A 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.

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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

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
	Necessary Contact Lenses	$25.00
Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Necessary Contact Lenses	$25.00
Payment Rates	For Covered Charges	100%

CGP-3-VSN-96-BEN3 B505.0004

VISION CARE EXPENSE INSURANCE

This insurance will pay many of your and your covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

CGP-3-VSN-96-VIS B505.0007

All Options

Vision Service Plan - This Plan's Vision Care Preferred Provider Organization

Vision Service Plan

This *plan* is designed to provide high quality vision care 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 Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

This vision care 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 current provider of VSP; and (b) has a participatory agreement in force with VSP.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from any vision care 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 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, *copayments, deductibles,* payment rates and payment limits.

The *covered person* can call VSP 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 a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider.*

Replacement Of Preferred Provider

If a *preferred provider* terminates his or her relationship with VSP for any reason, VSP shall be responsible for furnishing vision services to *covered persons* either through that provider or through another VSP *preferred provider.*

Pre-Authorization Of Preferred Provider Services

When a *covered person* desires to receive treatment from a *preferred provider,* the *covered person* must contact the *preferred provider* BEFORE receiving treatment. The *preferred provider* will contact VSP to verify the *covered person's* eligibility and VSP will notify the *preferred provider* of the 60 day time period during which the *covered person* may schedule an appointment. If the *covered person* cancels an appointment and reschedules it, it must be done within those 60 days. If the appointment is not rescheduled during the previously approved time period, the *covered person* must contact the *preferred provider* again to receive authorization.

What we pay is subject to all the terms of this *plan.*

CGP-3-VSN-96-PPOA B505.0009

All Options

Pre-Treatment Review For Necessary Contact Lenses

Subject to prior approval by VSP consultants, we will pay benefits for Necessary Contact Lenses provided to a *covered person.* A *covered person's* doctor must request approval for Necessary Contact Lenses from VSP.

No benefits will be paid for Necessary Contact Lenses if prior approval is not received from VSP.

What we pay for Necessary Contact Lenses is subject to all of the terms of this *plan.*

CGP-3-VSN-96-PTR2 B505.0014

All Options

Claim Appeals And Arbitration Of Disputes

If, under the provisions of this *plan,* a claim for benefits is denied in whole or in part, a request, in writing, may be submitted to VSP for a full review of the denial.

The written request must be made to the Plan Administrator within 60 days following the denial of benefits. The request should contain sufficient information to identify the *covered person* whose benefits were denied. This includes the name of the *covered person,* the *employee's* social security number and the *employee's* date of birth. The *covered person* may state the reasons he or she believes that the denial of the claim was in error and may provide any pertinent documents which he or she wishes to be reviewed. The Plan Administrator will review the claim and give the *covered person* the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of the Plan Administrator, including specific reasons for the decision, shall be provided and communicated to the *covered person* in writing within one hundred twenty (120) days after receipt of a request to review.

Any dispute or question arising between VSP and any *covered person* involving the application, interpretation or performance under this *plan* shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation. If any issue cannot be resolved in this fashion, it may be submitted to arbitration, if both parties agree.

The procedure for arbitration shall be conducted pursuant to the rules of the American Arbitration Association.

Preferred Provider Grievance Procedures

Grievances are handled by VSP's Professional Relations Vice President for action. The grievance process is designed to address *covered persons'* concerns quickly and satisfactorily. The following grievance procedures have been established:

(1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.

(2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.

(3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person.* Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.

(4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.

(5) All complaints will be retained in the Professional Relations Department.

Complaints and grievances may be sent to the Professional Relations Vice President at:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(877) 814-8970 or (800) 877-7195

CGP-3-VSN-96-APP B505.0015

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. The services and supplies covered under this *plan* are explained in the "Covered Services and Supplies" section of this *plan.* 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.

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider,* the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider.* We pay benefits for the covered charges a *covered person* incurs in excess of the *copayment.* This *plan's copayments* are as follows:

For each vision examination from a *preferred provider* $10.00

For each pair of *standard frames* and/or *standard lenses* from a *preferred provider* $25.00

For Necessary Contact Lenses from a *preferred provider* $25.00

Payment Limits Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *plan.* When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates Once a *covered person* has paid any applicable *copayment,* we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan.*

For covered charges 100%

Discounts If a *covered person* receives a vision examination, and lenses or frames from a *preferred provider,* he or she will receive a discount on the cost of purchasing an unlimited number of prescription glasses and non-prescription sunglasses from the any *preferred provider.* The *covered person* may also receive a discount on the costs of evaluation and fitting of contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination.

The discounts are:

For Prescription Glasses . . . . . 20% off of the *preferred provider's usual* and *customary* fee

Services or Supplies From a Preferred Provider (Cont.)

For Non-Prescription Sunglasses	20% off of the *preferred provider's usual* and *customary* fee
For Contact Lens Evaluation and Fitting Costs	15% off of the *preferred provider's usual* and *customary* fee

CGP-3-VSN-96-BEN1 B505.0933

All Options

Services or Supplies From a Non-Preferred Provider

If a *covered person* uses the services of a *non-preferred provider,* the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. The benefits we pay are subject to all of the terms of this *plan.*

Cash Deductible For Services Of A Non-Preferred Provider

There are separate cash *deductibles* for each covered service provided by a *non-preferred provider.* These cash *deductibles* are shown below. The *covered person* must have covered charges in excess of the cash *deductible* before we pay him or her any benefits for the service or supply.

For each vision examination provided by a *non-preferred provider* . . .	$10.00
For each pair of *standard frames* and/or *standard lenses* from a non-preferred provider	$25.00
For each pair of Necessary Contact Lenses from a *non-preferred provider*	$25.00

Payment Limits

Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *plan.* When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates

Once a *covered person* has met any applicable *deductible,* we pay benefits for covered charges under this *plan* as follows. What we pay is subject to all of the terms of this *plan.*

For covered charges	100%

CGP-3-VSN-96-BEN2 B505.0021

Covered Charges

Covered charges are the *usual* and *customary* 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.

Covered Services and Supplies

This section lists the types of charges we cover. But 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.

All covered vision services must be furnished by or under the direct supervision of an optometrist, ophthalmologist or other licensed or qualified vision care provider. The services or supplies must be the *usual* and *customary* treatment for a vision condition.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. When a vision examination indicates that new lenses or frames or both are *visually necessary and appropriate* for the proper visual health of a *covered person,* professional services covered by this *plan* include:

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

We don't cover more than one vision examination in any calendar year period.

And if a *covered person* uses a *non-preferred provider,* we limit what we pay for each vision examination to $39.00.

CGP-3-VSN-96-LIST1 B505.0935

All Options

Standard Lenses

We cover charges for single vision, bifocal, trifocal or *lenticular lenses.* We cover glass, plastic or for dependent children to age 26, polycarbonate lenses.

If a *covered person* uses a *non-preferred provider,* we limit what we pay to

- $23.00 for each pair of single vision lenses

- $37.00 for each pair of bifocal lenses
- $49.00 for each pair of trifocal lenses and
- $64.00 for each pair of *lenticular lenses.*

CGP-3-VSN-05-SL B505.0453

All Options

We do not cover charges for more than one set of *standard lenses* in any 12 month period.

CGP-3-VSN-05-SL B505.0455

All Options

Standard Frames

We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of $130.00, plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $46.00.

We don't cover charges for more than one set of standard frames in any 24 month period.

If the covered person chooses elective contact lenses, we do not cover standard frames for 24 months from the date the elective contacts are purchased.

CGP-3-VSN-05-SF B505.1261

All Options

Necessary Contact Lenses

We cover charges for Necessary Contact Lenses upon prior approval by VSP. We cover charges, and charges for related professional services, only if the lenses are needed:

(a) following cataract surgery;

(b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

(c) for certain conditions of *anisometropia;* or

(d) for *keratoconus.*

We don't cover charges for more than one pair of Necessary Contact Lenses in any 12 month period.

If a *covered person* receives Necessary Contact Lenses from a *preferred provider,* we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider,* we limit what we pay to $210.00 in any 12 month period.

CGP-3-VSN-96-LIST7 B505.0028

All Options

Elective Contact Lenses

We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses for 12 months and standard frames for at least 24 months.

We limit what we pay for elective contact lenses to $130.00 once every 12 months.

CGP-3-VSN-05-ECL B505.0427

All Options

Special Limitations

If This VSP Plan Replaces Another VSP Plan

If, prior to being covered under this *plan,* a *covered person* was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this *plan,* the date he or she received such a covered service will be used as the last date of service when applying the *benefit period* limitations under this *plan.* We apply this provision only if the *covered person* was enrolled in another VSP plan immediately before enrolling in this *plan.*

CGP-3-VSN-96-SL1 B505.0031

All Options

Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental testing.
- 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.

CGP-3-VSN-96-EXC1 B505.0034

All Options

- We will not pay for plano lenses (lenses with less than a .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not 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 will not pay for blended lenses.
- We will not pay for oversized lenses.
- We will not pay for the laminating of the lens or lenses.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for UV (ultraviolet protected lenses).
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

- We will not pay for progressive multifocal lenses.
- We will not pay for the coating of the lens or lenses.
- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

CGP-3-VSN-05-EXC B505.0428

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments* or *deductibles,* if any.

CGP-3-VSN-96-EXC17 B505.0037

CERTIFICATE AMENDMENT

(To be attached to certificates issued to employees) The certificate is amended as follows:

This plan's Employee Basic Life "Settlement Option" provision of the Life Certificate is modified as follows:

Settlement Option: Unless otherwise elected by the certificate holder or beneficiary, benefits will be paid in a single lump sum check. We may make other options available in addition to the single check option.

This rider is 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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A B531.0114

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

Senior Vice President, Group and Worksite Markets

B531.0684

CGP-3-A-REV-CA-18

Option A

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follows when titanium or high noble metal (gold) is used in a *dental prosthesis.*

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 missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a *dental prosthesis,* the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

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

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DGOPT-10 B531.0029

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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-A-1 B505.1291

All Options

Limitations and Exclusions:

1. Limitations and exclusions of benefits described in the Plan for VSP Preferred Providers shall also apply to services and supplies received from Affiliate Providers.
2. If a service or supply is not covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by this Plan when received from an Affiliate Provider.
3. Services and supplies received from an Affiliate Provider are in lieu of services and supplies received from a VSP Preferred Provider or a Non-Preferred Provider. Membership may be required in order to access benefits through an Affiliate Provider. Membership fees are not covered under this Plan.

B505.1566

All Options

4. We do not cover charges for:
    - Medically Necessary Contact Lenses.

B505.1447

All Options

Definitions:

The following definition is added to the definitions shown in the Plan.

The term "Affiliate Provider" means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this section. Not all Affiliate Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at (800) 877-7195 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Plan.

The term "Copayment" means a charge, expressed as a fixed dollar amount, required to be paid by, or on behalf of, a Covered Person to a Preferred Provider or an Affiliate Provider at the time covered vision services or supplies are received.

This rider is 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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-A-VSN-AFFIL-CA-13 B531.0319

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 A

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.

(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 A

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.

Option A

CERTIFICATE AMENDMENT

Notwithstanding any provision in the Plan to the contrary, it is hereby agreed that the Group Plan is amended January 1, 2017 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 of 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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-1-A-CAL-PR B590.9027

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

All Options

Anisometropia means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.

CGP-3-VSN-96-DEF1 B750.0457

Option A

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

CGP-3-GLOSS-90 B750.0664

Option A

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

CGP-3-GLOSS-90 B750.0665

All Options

Benefit Period with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan,* the covered service is again available to a *covered person.*

CGP-3-VSN-96-DEF3 B750.0458

Option A

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-VSN-96-DEF3 B750.0459

All Options

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

CGP-3-VSN-96-DEF3 B750.0460

All Options

Copayment with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.

CGP-3-VSN-96-DEF3 B750.0461

Option A

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

CGP-3-GLOSS-90 B750.0667

Option A

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 A

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-VSN-96-DEF3 B750.0462

All Options

Customary with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn't more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-VSN-96-DEF3 B750.0484

All Options

Deductible with respect to Vision Care Insurance, means any amount which a *covered person* must pay before he or she is reimbursed for covered services provided by a *non-preferred provider.*

CGP-3-VSN-96-DEF3 B750.0483

Option A

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 A

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 A

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 RIO VISTA DEVELOPMENT COMPANY .

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

Incurred, Or Incurred Date with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

CGP-3-VSN-96-DEF3 B750.0466

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 A

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 coneshaped due to a thinning and stretching of the tissue in its central area.

CGP-3-VSN-96-DEF11 B750.0467

All Options

Lenticular Lenses mean 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-VSN-96-DEF11 B750.0485

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 A

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, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the *plan* to provide vision care services and/or vision care materials to *covered persons* of the *plan.*

CGP-3-VSN-96-DEF14 B750.0487

Option A

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. This *plan* does not pay benefits for *orthodontic treatment.*

CGP-3-GLOSS-90 B750.0685

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-VSN-96-DEF16 B750.0472

All Options

Oversize lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

CGP-3-VSN-96-DEF17 B750.0489

Option A

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 A

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

CGP-3-GLOSS-90 B750.0677

All Options

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

CGP-3-VSN-96-DEF17 B750.0490

Option A

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 A

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

CGP-3-GLOSS-90 B750.0678

Option B

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 Benefits with respect to Vision Care Insurance, mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan.*

CGP-3-VSN-96-DEF17 B750.0492

All Options

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

CGP-3-VSN-96-DEF17 B750.0491

Option A

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 contracted with the *plan* to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan.*

CGP-3-VSN-96-DEF14 B750.0488

Option A

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 A

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 Frames mean frames valued up to the limit published by VSP which is given to *preferred providers.*

CGP-3-VSN-96-DEF17 B750.0478

All Options

Standard Lenses mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.

CGP-3-VSN-96-DEF17 B750.0479

All Options

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

CGP-3-VSN-96-DEF17 B750.0480

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-VSN-96-DEF17 B750.0481

All Options

Visually Necessary Or Appropriate means medically or visually necessary for the restoration or maintenance of a *covered person's* visual acuity and health and for which there is no less expensive professionally acceptable alternatives.

CGP-3-VSN-96-DEF17 B750.0482

Option A

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

CGP-3-GLOSS-90 B750.0683

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.

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 A

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0076

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 l 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

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.

B752.0188

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.

B752.0103

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.

B752.0104

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".

B815.0261

CERTIFICATE OF COVERAGE

Guardian
10 Hudson Yards
New York, New York 10001

We, Guardian, certify that the *employee* named below is entitled to the insurance benefits provided by *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 *Guardian.*

The Guardian Life Insurance Company of America

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

B815.0004

CGP-CA-10

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/

B815.0314

TABLE OF CONTENTS

The forms listed below are attached to and made part of this certificate. The listed forms describe the coverages which the *Planholder* has elected.

All terms in italics are defined terms with special meanings. Definitions are shown in the Glossary or are defined where they are used.

B815.0006

Vision Care Expense Insurance

B815.0007

GENERAL PROVISIONS

As used in this certificate:

"Accident and health" means any vision insurance provided by this *plan.*

"Covered person" means *you* or any of *your* dependents insured by this *plan,* except in the "Repayment" section where "covered person" has a special meaning. See that section for details.

"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.

"Employer" and "Planholder" mean the employer who purchased this *plan.*

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

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

"You," "your," and "certificateholder" mean an *employee* covered by this *plan.*

B815.0010

Limitation of Authority

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: (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 *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.

Incontestability

(a) After two years from the insured's date of coverage under this plan, no misstatements, except fraudulent misstatements, made by the insured in the application for such coverage shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the two-year period.

(b) No claim for loss incurred or disability (as defined on the policy) commencing after two years from the insured's date of coverage under this plan shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the insured's effective date of coverage under this *plan.*

B815.0014

Vision Claims Provisions

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

Notice Written notice of an injury or sickness for which a claim is being made must be given to *us* 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, the dependent's name should also be noted.

We will not void or reduce a claim if notice is not given within the required time. But, notice must be given to *us* as soon as reasonably possible.

Claim Forms *We* will provide forms for filing proof of loss within 15 days of receipt of notice. But if *we* do not provide the forms on time, *we* will accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. The nature and extent of the loss for which the claim is being made must be detailed.

Proof of Loss Written proof of loss must be furnished to *us* at *our* designated office.

This proof must be furnished within 90 days of the loss.

We will not void or reduce a claim if proof is not given within the required time. But, proof must be given as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required.

Claims Communications *We* will reply, not later than the 30th day after receipt, to all pertinent communications about a pending claim from a claimant that reasonably indicates a response is expected.

Payment of Benefits *We* completely discharge our liability for any amounts paid as follows:

We will pay vision benefits as soon as *we* receive written proof of loss.

Unless otherwise required by law or regulation, *we* pay all vision benefits to *you* if *you* are living. If *you* or any other payee is not living, *we* have the right to pay all vision benefits, to one of the following: (a) *your* estate; (b) *your* spouse; (c) *your* parents; (d) *your* children; (e) *your* brothers and sisters; or (f) any unpaid provider of health care services.

When proof of loss is filed, *you* or any other payee 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. But, *we* can not require that a particular provider provide such care. And, *you* or any other payee may not assign *your* right to take legal action under this *plan* to such provider.

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 the death, where allowed by law. *We* will pay for all such examinations and autopsies.

Legal Actions No legal action against this *plan* will be brought until 60 days from the date proof of loss has been given as stated above. And, no legal action will be brought against this *plan* after 3 years from the date written proof of loss is required to be given.

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

B815.0015

All Options

Repayment

We will not pay any benefits under this *plan,* to or on behalf of a *covered person,* who has received payment in whole from a *third party,* or its insurer for past or future vision charges, resulting from the negligence, intentional act, or no-fault tort liability of a *third party.*

If a *covered person* or his or her beneficiary makes a claim to *us* for vision charges, under this *plan* prior to receiving payment from a *third party* or its insurer, the *covered person* or his or her beneficiary must agree, in writing, to repay *us* from any amount of money they receive from the *third party,* or its insurer. This agreement will not apply to any damages awarded by a court for pain and suffering.

The repayment will be equal to the amount of benefits paid by *us.* However, the *covered person* or his or her beneficiary may deduct the *reasonable pro-rata expenses incurred* in effecting the *third party* payment from the repayment to *us.*

The repayment agreement will be binding upon the *covered person* or his or her beneficiary whether: (a) the payment received from the *third party,* or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the *third party,* or its insurer, has admitted liability for the payment; or (c) the vision charges, are itemized in the *third party* payment.

As used in this provision:

"Covered person" means *you* or your dependent, including the legal representative of a minor or incompetent, insured by this *plan.*

"Reasonable pro-rata expenses" are those costs, such as lawyers fees and court costs, *incurred* to effect a third party payment, expressed as a percentage of such payment.

"Third party" means anyone other than *Guardian,* the *employer* or the *covered person.*

B815.0017

All Options

YOUR CONTINUATION RIGHTS

Coordination Between Continuation Sections

A *covered person* may be eligible to continue his or her 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 or she chooses to continue his or her 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.

B815.0018

All Options

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.*

B815.0019

All Options

Federal Continuation Rights

Important Notice This notice contains important information about the right to continue group health 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 provision applies only to any vision coverage which is part of this *plan.* In this provision, this coverage is referred to as "group health benefits."

This provision 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 provision.

Under this provision, "qualified continuee" means any person who, on the day before any event which would qualify him or her for continuation under this provision, 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 provision is not a qualified continuee.

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 the "When Continuation Ends" section.

Extra Continuation for Disabled Qualified Continuees

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

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

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

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.

B815.0272

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 the "When Continuation Ends" section.

B815.0024

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 the "When Continuation Ends" section.

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 the "When Continuation Ends" section.

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

B815.0025

All Options

Your Employer's Responsibilities

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

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified coninuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; (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 an insured dependent child; or (c) the date *your employer* declares bankruptcy under Title 11 of the United States Code.

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 the " Extra Continuation for Disabled Qualified Continuees" section, an additional charge of two percent of the total premium charge may also be required by *your employer.*

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

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

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

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

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

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

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

B815.0026

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in *your* certificate.

General Definitions

Active Work, Actively-At-Work Or Actively Working means *you* are able to perform and are performing all the regular duties of *your* work for *your employer* and working *your* regular number of hours at: (a) one of *your employer's* usual places of business; (b) some place where *your employer's* business requires *you* to travel; or (c) any other place *you* and *your employer* have agreed on for *your* work

B815.0030

All Options

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

B815.0031

All Options

Enrollment Period for dependent coverage is the 31 day period which starts on the date that *you* first become eligible for dependent coverage.

B815.0032

All Options

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

B815.0033

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.*

B815.0035

All Options

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

B815.0036

All Options

Definitions Applicable to Vision Care Expense Coverage

B815.0039

All Options

Anisometropia means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.

B815.0040

All Options

Benefit Period means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan,* the covered service is again available to a *covered person.*

B815.0041

All Options

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

B815.0042

All Options

Coated Lenses mean finished lenses that have a substance added on one or both surfaces.

B815.0043

All Options

Copayment means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.

B815.0044

All Options

Incurred, Or Incurred Date means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

B815.0045

All Options

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

B815.0046

All Options

Lenticular Lenses mean 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.

B815.0047

All Options

Low Vision means a partial loss of vision. It is a loss of acuity or sharpness or a loss of side vision.

B815.0048

All Options

Necessary Contact Lenses are contact lenses needed:

(a) following cataract surgery;

(b) to correct extreme visual acuity problems that can not be corrected spectacle lenses;

(c) for certain conditions of anisometropia; or

(d) for keratoconus.

B815.0049

All Options

Non-Preferred Provider means any licensed and qualified provider acting within the scope of his or her license who has not contracted with this *plan's* PPO to provide services and/or materials to a *covered person.*

B815.0050

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.

B815.0051

All Options

Oversize Lenses mean larger than a *standard lens* blank, to accommodate prescriptions.

B815.0052

All Options

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

B815.0053

All Options

Plan Benefits mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan.*

B815.0054

All Options

Plano Lenses mean lenses which have no refractive power (lenses with less than a .38 diopter power).

B815.0055

All Options

Preferred Provider means any licensed and qualified provider acting within the scope of his or her license who has contracted with the *plan's* PPO to provide services and/or materials to a *covered person.*

B815.0056

All Options

Standard Frames mean frames valued up to the limit published by VSP which is given to *preferred providers.*

B815.0057

All Options

Standard Lenses mean regular glass or plastic lenses.

B815.0058

All Options

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

B815.0059

All Options

Visually Necessary means that your provider has determined the service or supply to be essential for the restoration or maintenance of a *covered person's* visual acuity and health.

B815.0060

All Options

The Guardian Life Insurance Company of America

VISION CARE EXPENSE INSURANCE

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B815.0062

All Options

Employee Coverage

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

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

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

Once *you* enroll in this *plan, you* can not drop *your* vision coverage until this *plan's* next vision open enrollment period. And if *you* drop *your* vision coverage, *you* can not 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 the vision coverage under this *plan* within 30 days of the date that any of these events occur.

B815.0067

All Options

When Your Coverage Starts

Your coverage under this *plan* is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But *you* must be *actively at work* on 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 work.*

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

B815.0091

All Options

When Your Coverage Ends

Your coverage ends on the last day of the month in which *you* cease *active work* 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 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 vision care benefits for a limited time.

B815.0093

All Options

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 that 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.

B815.0264

All Options

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

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

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

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

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

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

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

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

B815.0099

All Options

Dependent Coverage

B815.0100

All Options

Eligible Dependents For Dependent Vision Care Benefits

Your *eligible dependents* are: (a) *your* spouse; and (b) *your* dependent children who are under age 26.

For the purpose of this Plan, the term spouse shall include *your* domestic partner which means an adult who has chosen to share his or her life with *you* in an intimate and committed relationship of mutual caring as defined under Section 297 of the California Family Code.

B815.0102

All Options

Adopted Children and Step-Children

Your "dependent children" include *your* legally adopted children and *your* step-children.

We treat a child as legally adopted from the time the child is placed in *your* 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.

B815.0104

All Options

Handicapped Children

You may have a child with a mental or physical handicap, or developmental disability, who is chiefly dependent upon *you* for support and maintenance. 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, subject to the conditions shown below.

- His or her condition started before he or she reached this coverage's age limit.
- He or she became Covered for dependent vision benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she is unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon you for most of his or her support and maintenance.
- You send us written proof of the child's disability and dependence within 31 days from the date he or she reaches the 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.

The child's coverage ends when *yours* does.

B815.0106

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 insured for employee coverage.

If *you* do this during the enrollment period, *your* dependent coverage is scheduled to start on the date *you* become insured for employee coverage.

If *you* do this after the *enrollment period* ends, *you* can not 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 not 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 not be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can not be enrolled again until the next vision open enrollment period.

B815.0107

All Options

Exception

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

B815.0109

All Options

Newborn Children

We cover *your* newborn child from the moment of his or her 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.

B815.0110

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of *your* dependents when *your* coverage ends. But if *you* die while insured, *we* will automatically continue dependent benefits for those of *your* dependents who are insured when *you* died. *We* will 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,* 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 provision.

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

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, or, for your handicapped child who has reached the age limit, when he or she marries, or is no longer dependent on *you* for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

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

B815.0112

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
	Necessary Contact Lenses	$25.00
Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or *Standard Lenses*	$25.00
	Necessary Contact Lenses	$25.00
Payment Rates	For Covered Services and Supplies	100%

B815.0118

VISION CARE BENEFITS

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

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All Options

Vision Service Plan
This Plan's Vision Care Preferred Provider Organization

Vision Service Plan

This *plan* is designed to provide high quality vision care 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 Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

This vision care 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 current provider of VSP; and (b) has a participatory agreement in force with VSP.

Use of the vision care PPO is voluntary. A *covered person* may receive vision care from any vision care 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 *you* and *your* 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 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, *copayments, deductibles,* payment rates and payment limits.

The *covered person* can call VSP 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 a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider.*

Replacement of Preferred Provider

If a *preferred provider* terminates his or her relationship with VSP for any reason, VSP will be responsible for furnishing vision services to *covered persons* either through that provider or through another VSP *preferred provider.*

Continuity Of Care - Terminated Provider: A covered person may request for the continuation of covered services to be rendered by a terminated Preferred Provider when he or she is undergoing treatment from a terminated provider for an acute condition or serious chronic, performance of surgery or other procedure authorized by VSP as part of a documented course of treatment that is to occur within 90 days of the contract termination date. This provision does not apply to Preferred Providers who voluntarily leave VSP. The request must be made in writing and sent to:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670

Or contact VSP's Member Services Department at (800) 622-7444 during normal business hours. The terminating Preferred Provider must accept the contracted rate for that covered person's treatment and agree not to seek payment from the covered person for any amounts for which the covered person would not be responsible if the provider were still on the network. The approval of the request to continue covered person's treatment will be at the VSP's discretion. VSP is not required to provide benefits that are not otherwise covered under the terms and conditions of the plan. In the event the terminating provider or covered person wishes to appeal an adverse decision, VSP will review the request and make the final determination.

This provision will not apply to any provider terminated for reasons relating to a disciplinary cause or reason, or fraud or other criminal activity.

Continuity Of Care - Arrangements With A Terminated Provider: VSP requires the terminated provider to agree in writing to be subject to the same contractual terms and conditions that are imposed upon currently contracted providers, including, but not limited to, credentialing, hospital privileging, utilization review, peer review, and quality assurance requirements. VSP is not required to continue the services a provider is providing to a covered person if the provider does not agree to comply or does not comply with these contractual terms and conditions.

Unless VSP and the provider agree otherwise, the services rendered pursuant to this policy shall be compensated at rates and methods of payment similar to those used by VSP for currently contracted providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the terminated provider. VSP is not required to continue the services a provider is providing to a covered person if the provider 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 provider are the same as would be paid by the covered person if receiving care from a provider currently contracted with VSP.

Pre-Authorization of Preferred Provider Services

When a *covered person* desires to receive treatment from a *preferred provider,* the *covered person* must contact the *preferred provider* BEFORE receiving treatment. The *preferred provider* will contact VSP to verify the *covered person's* eligibility and VSP will notify the *preferred provider* of the 60 day time period during which the *covered person* may schedule an appointment. If the *covered person* cancels an appointment and reschedules it, it must be done within those 60 days. If the appointment is not rescheduled during the previously approved time period, the *covered person* must contact the *preferred provider* again to receive authorization.

What *we* pay is subject to all the terms of this *plan.*

B815.0124

All Options

Pre-Treatment Review for Necessary Contact Lenses

Subject to prior approval by VSP consultants, *we* will pay benefits for necessary contact lenses provided to a *covered person.* A *covered person's* doctor must request approval for necessary contact lenses from VSP.

No benefits will be paid for necessary contact lenses if prior approval is not received from VSP.

What *we* pay for necessary contact lenses is subject to all of the terms of this *plan.*

B815.0127

All Options

Claim Appeals and Arbitration of Disputes

If, under the provisions of this *plan,* a claim for benefits is denied in whole or in part, a request, in writing, may be submitted to VSP for a full review of the denial.

The written request must be made to VSP within 60 days following the denial of benefits. The request should contain sufficient information to identify the *covered person* whose benefits were denied. This includes the name of the *covered person, your* social security number and the *your* date of birth. The *covered person* may state the reasons he or she believes that the denial of the claim was in error and may provide any pertinent documents which he or she wishes to be reviewed. VSP will review the claim and give the *covered person* the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of VSP, including specific reasons for the decision, will be provided and communicated to the *covered person* in writing within one hundred twenty (120) days after receipt of a request to review.

Any dispute or question arising between VSP and any *covered person* involving the application, interpretation or performance under this *plan* shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation.

Preferred Provider Grievance Procedures

Grievances are handled by VSP's Professional Relations Vice President for action. The grievance process is designed to address *covered person's* concerns quickly and satisfactorily. The following grievance procedures have been established:

(1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.

(2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.

(3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person.* Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.

(4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.

(5) All complaints will be retained in the Professional Relations Department.

Complaints and grievances may be sent to the Professional Relations Vice President at:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(800) 622-7444

B815.0128

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. The services and supplies covered under this *plan* are explained in the "Covered Services and Supplies" section of this *plan.* 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.

Services or Supplies From a Preferred Provider

If a *covered person* uses the services of a *preferred provider,* the *preferred provider* must receive approval from VSP prior to providing the *covered person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *plan* for specific requirements.

Copayments The *covered person* must pay a *copayment* when he or she receives services from a *preferred provider. We* pay benefits for the covered charges a *covered person* incurs in excess of the *copayment.* This *plan's copayments* are as follows:

For each vision examination from a *preferred provider* $10.00

For each pair of *standard frames* and/or *standard lenses* from a *preferred provider* $25.00

For necessary contact lenses from a *preferred provider* $25.00

Payment Limits Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *plan.* When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates Once a *covered person* has paid any applicable *copayment, we* pay benefits for covered charges under this *plan* as follows. What *we* pay is subject to all of the terms of this *plan.*

For covered services and supplies 100%

B815.0141

All Options

Services or Supplies From a Non-Preferred Provider

If a *covered person* uses the services of a *non-preferred provider,* the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received. The benefits *we* pay are subject to all of the terms of this *plan.*

Cash Deductible for Services of a Non-Preferred Provider

There are separate cash *deductibles* for each covered service provided by a *non-preferred provider.* These cash *deductibles* are shown below. The *covered person* must have covered charges in excess of the cash *deductible* before *we* pay him or her any benefits for the service or supply.

For each vision examination provided by a *non-preferred provider* . . . $10.00

For each pair of *standard frames* and/or *standard lenses* from a non-preferred provider $25.00

For each pair of necessary contact lenses from a *non-preferred provider* $25.00

Payment Limits

Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *plan.* When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates

Once a *covered person* has met any applicable *deductible, we* pay benefits for covered charges under this *plan* as follows. What *we* pay is subject to all of the terms of this *plan.*

For covered services and supplies 100%

B815.0142

All Options

Covered Charges

Covered charges are the 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. If more than one type of service can be used to treat a condition, we have the right to base benefits on the least expensive service or supply.

Covered Services and Supplies

This section lists the types of charges we cover. But 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.

All covered vision services must be furnished by or under the direct supervision of an optometrist, ophthalmologist or other licensed or qualified vision care provider.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. When a vision examination indicates that new lenses or frames or both are *visually necessary,* professional services covered by this *plan* include:

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- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

We don't cover more than one vision examination in any calendar year period.

And, if a *covered person* uses a *non-preferred provider,* we limit what we pay for each vision examination to $39.00 in any calendar year period.

B815.0131

All Options

Standard Lenses We cover charges for single vision, bifocal, trifocal or *lenticular lenses.* We cover glass, plastic or for dependent children to age 26, polycarbonate lenses.

If a *covered person* uses a *non-preferred provider,* we limit what we pay to

- $23.00 for each pair of single vision lenses
- $37.00 for each pair of bifocal lenses
- $49.00 for each pair of trifocal lenses and
- $64.00 for each pair of *lenticular lenses.*

B815.0151

All Options

We cover charges for one pair of *standard lenses* in any calendar year *benefit period.*

B815.0171

All Options

Standard Frames We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of $130.00, plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $46.00.

If the covered person chooses elective contact lenses, we do not cover standard frames until the beginning of the calendar year following the next calendar year after the date the elective contacts are purchased.

We cover charges for one set of standard frames in any period of 2 calendar years.

B815.0197

All Options

Necessary Contact Lenses

We cover charges for Necessary Contact Lenses and charges for related professional services only upon prior approval by VSP. See "Pre-Treatment Review for Necessary Contact Lenses" for Details.

We limit what we pay for Necessary Contact Lenses to $210.00 in any calendar year period.

B815.0205

All Options

Elective Contact Lenses

We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses until the next calendar year and standard frames for a period of 2 calendar years.

If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to $130.00

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to $100.00.

We cover charges for one set of elective contact lenses in any calendar year period.

B815.0214

All Options

Special Limitations

If this VSP Plan Replaces Another VSP Plan

If, prior to being covered under this *plan,* a *covered person* was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this *plan,* the date he or she received such a covered service will be used as the last date of service when applying the *benefit period* limitations under this *plan. We* apply this provision only if the *covered person* was enrolled in another VSP plan immediately before enrolling in this *plan.*

B815.0227

All Options

Exclusions

We won't pay for:

- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.

B815.0231

All Options

We won't pay for:

- A frame that costs more than the plan allowance.
- *Plano lenses.*
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this *plan* which are lost or broken, except at normal intervals when services are otherwise available.
- Expenses associated with securing materials such as lenses and frames.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses such as polishing or cleaning.
- Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

B815.0232

All Options

- *We* won't pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

B815.0233

All Options

- *We* won't pay for UV (ultraviolet) protected lenses.

B815.0234

All Options

- *We* won't pay for the scratch resistant coating of the lens or lenses.

B815.0235

All Options

- *We* won't pay for blended lenses.

B815.0236

All Options

- *We* won't pay for high index lenses.

B815.0237

All Options

- *We* won't pay for mirror/ski coating of the lens or lenses.

B815.0238

All Options

- *We* won't pay for oversized lenses.

B815.0239

All Options

- *We* won't pay for laminating of the lens or lenses.

B815.0240

All Options

- *We* won't pay for edge treatment.

B815.0241

All Options

- *We* won't pay for progressive lenses.
- *We* won't pay for progressive multifocal lenses.

B815.0242

All Options

- *We* won't pay for anti-reflective coating of the lens or lenses.

B815.0243

All Options

- *We* won't pay for polycarbonate lenses.

B815.0244

All Options

Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments* or *deductibles,* if any.

B815.0245

SAMPLE BENEFIT CALCULATOR

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

A *covered person* may receive covered services or supplies from a VSP *preferred provider.* He or she may also receive covered services from any other vision care provider. But, this *plan* usually pays more in benefits for covered services furnished by a *preferred provider.* The example below shows how benefits may differ.

The benefits shown below are for illustration only. Read this plan carefully to determine actual covered services, copayments, deductibles, payment rates or payment levels.

Example of In and Out-of-Network Benefits
For Split Copayment, Full-Service Plan

Preferred Provider - Split Copayment Plan

Cost of Exam:	Paid by VSP
Copayment Applied to Exam:	**$10.00**
Cost of Standard Lenses:	Paid by VSP
Cost of Standard Frames:	Paid by VSP
Copayment Applied to Lenses:	**$20.00**
Copayment Applied to Frames:	**$20.00**
Insured's Total Costs:	**$50.00**

Non-Preferred Provider - Split Copayment Plan

Cost of Exam:	$65.00
Deductible Applied to Exam:	**$10.00**
Remainder:	$55.00
Exam Allowance:	$35.00
Insured Pays Additional:	**$20.00**

Cost of Lenses:	$55.00
Deductible Applied to Lenses:	**$20.00**
Remainder:	$35.00
Lens Allowance:	$25.00
Insured Pays Additional:	**$10.00**
Cost of Frames:	$80.00
Deductible Applied to Frames:	**$20.00**
Remainder:	$60.00

Frame Allowance:	$35.00
Insured Pays Additional:	**$25.00**
Insured's Total Costs:	**$105.00**

B815.0247

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CERTIFICATE RIDER

To add the following to the Vision Care Covered Services and Supplies:

Elective Contact Lens Fitting and Evaluation Services: We cover charges for fitting and evaluation services received from a Preferred Provider for elective contact lenses that are covered under this plan. Coverage under this section does not include charges for contact lens materials.

We cover charges for no more than one elective contact lens fitting and evaluation for each Covered Person in any one calendar year *benefit period*.

The Covered Person must pay a Copayment of up to $60.00 each time he or she receives an elective contact lens fitting and evaluation. We pay benefits in full for the covered charges a Covered Person incurs in excess of the Copayment.

As used herein:

Elective Contact Lenses means contact lenses that are not prescribed for conditions in which visual acuity cannot be adequately corrected with eyeglasses as determined by the Preferred Provider.

The Covered Person determines if he or she wants to receive elective contact lenses.

This rider is 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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-A-VSP-DEC-CA-13 B531.0263

All Options

CERTIFICATE RIDER

To add the following to the Vision Care Covered Services and Supplies:

Services and Supplies Received from Affiliate Providers: Vision care services and supplies that are covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider may also be covered by this Plan when such services and supplies are received from, an Affiliate Provider, subject to the limitations and exclusions below.

If services and supplies are received from an Affiliate Provider, We pay benefits for covered charges after the Copayment, as shown below:

SERVICES AND SUPPLIES	AFFILIATE PROVIDER - COSTCO	OTHER AFFILIATE PROVIDERS
Eye Exam - one in any one calendar year Period.	Covered In Full.	Covered In Full.

B531.0291

All Options

Standard Lenses - one pair in any one calendar year Period.		
• Single Vision	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
• Bifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
• Trifocal	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)
• Lenticular	Not Available.	Covered In Full. (Not all lens types may be available at all locations.)
Lens Options - once in any one calendar year Period.	Covered In Full. (Not all lens types may be available at all locations.)	Covered In Full. (Not all lens types may be available at all locations.)

B505.1436

All Options

SERVICES AND SUPPLIES	AFFILIATE PROVIDER - COSTCO	OTHER AFFILIATE PROVIDERS
Standard Frames - one set in any 2 calendar year Period.	Covered In full up to $70.00. ● No discount available on charges in excess of the benefit amount.	Covered In full up to $130.00

B531.0324

All Options

Elective Contact Lenses - one set in any one calendar year Period.		
● Contact Lens (Materials Only)	Covered In full up to $130.00.	Covered In full up to $130.00

B531.0326

All Options

Limitations and Exclusions:

1. Limitations and exclusions of benefits described in the Plan for VSP Preferred Providers shall also apply to services and supplies received from Affiliate Providers.
2. If a service or supply is not covered by this Plan when received from a Preferred Provider or a Non-Preferred Provider, such service or supply is not covered by this Plan when received from an Affiliate Provider.
3. Services and supplies received from an Affiliate Provider are in lieu of services and supplies received from a VSP Preferred Provider or a Non-Preferred Provider. Membership may be required in order to access benefits through an Affiliate Provider. Membership fees are not covered under this Plan.

B505.1566

All Options

4. We do not cover charges for:
   - Medically Necessary Contact Lenses.

B505.1447

All Options

Definitions:

The following definition is added to the definitions shown in the Plan.

The term "Affiliate Provider" means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this section. Not all Affiliate Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at (800) 877-7195 for details.

The following definition replaces the definition of the term "Copayment" as it is shown in the Plan.

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The term "Copayment" means a charge, expressed as a fixed dollar amount, required to be paid by, or on behalf of, a Covered Person to a Preferred Provider or an Affiliate Provider at the time covered vision services or supplies are received.

This rider is 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

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-A-VSN-AFFIL-CA-13 B531.0319

CGP-A-VSN-AFFIL-CA-13

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

(b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

(c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B815.0250

All Options

The Guardian's Responsibilities

B815.0252

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.

B815.0253

All Options

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

B815.0255

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

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 your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

B815.0257

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.

Candee Bolyog
President, Managed Dental Care

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.

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures

Eligible Employees may enroll for dental coverage by filling out and signing the appropriate enrollment form and any additional material required by your Employer and returning the enrollment material to your Employer.

After your enrollment material has been received by MDC, you or your Dependents need only to contact the selected and assigned Primary Care Dentist's office to obtain services.

MDC will issue You and your Dependents, either directly or through your Employer's representative, an MDC identification (ID) card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

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.

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. You may request a copy of MDC's written policy, which includes information on how you may request a review under this Plan.

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 us 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) Dependent Child who has reached the upper age limit of a Dependent Child, who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness or condition, and is chiefly dependent upon 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:

In order for a domestic partner to be treated as a spouse under this Plan, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- Share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the Employee's state of residence; and

- Be financially interdependent which must be demonstrated by at least four of the following:

  a. ownership of a joint bank account;

  b. ownership of a joint credit account;

  c. evidence of a joint mortgage or lease;

  d. evidence of joint obligation on a loan;

  e. joint ownership of a residence;

  f. evidence of common household expenses such as utilities or telephone

  g. execution of wills naming each other as executor and/or beneficiary;

  h. granting each other durable powers of attorney;

  i. granting each other health care powers of attorney;

  j. designation of each other as beneficiary under a retirement benefit account; or

  k. evidence of other joint financial responsibility.

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

Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the Employer. Once the Employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner will not be eligible for continuation of dental coverage as explained: (a) under the "Federal continuation Rights" section; and (b) under any other continuation rights section of this Plan, unless the Employee is also eligible for and elects continuation.

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. Coverage takes effect on the first day of the month of schedule effective date.

Any disputes or inquires regarding your eligibility, renewal, reinstatement and the like, should be directed to your Employer. 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.

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 were received by MDC; or (b) the first day of the month after the end of any waiting period your Employer may require.

When Dependent Coverage Starts

Except as stated below, your Dependents will be eligible for coverage on the later of: (a) the date 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) a stepchild; or (b) a foster child, coverage begins on the date that child begins to reside in Your home. If the Dependent is an adopted child, coverage begins on the date that the child is subject to a legal suit for adoption. If a newborn child, adopted child or foster child becomes covered under this Plan, You must complete enrollment materials for such Dependent within 30 days of his or her effective date of coverage.

Prepayment Fees (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 on the prepayment fee insert. Contact your Employer for questions regarding any sums to be withheld from your salary.

The first premium payment for this Plan is due on the Plan effective date by 5:00 p.m. Further payments shall be made on the first day of each month by 5:00 p.m. for each month this Plan is in effect. The Planholder shall pay MDC the total sum indicated for each eligible Member. MDC may change such rates on the first day of any month. MDC must give the Planholder 31 days written notice of the rate change. Such change will apply to any premium due on or after the effective date of the change stated in such notice. Payment should be sent to address listed in the Group Contract.

Other Charges

Member is responsible for applicable Patient Charges listed on the Plan Schedule included in this EOC. Patient Charges are incurred by Members and due to their PCD when services are rendered.

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 the usual Patient Charges plus an added charge equal to the actual laboratory cost of the high noble metal.

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 Provisions

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.

CGP-3-MDC-CA-ELIG-A-08 B850.1469

Option B

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.

(2) The end of the month in which your Dependent is no longer a Dependent as defined in this Plan.

(a) MDC will send a notice to the subscriber at least 90 days prior to the dependent child attaining the limiting age that the dependent child's coverage will terminate when the child reaches the limiting age unless proof the child's physical or mental disability, injury or condition is received by MDC within 60 days of receiving the notice requesting the proof.

(b) MDC will make a determination as to whether the dependent child is entitled to continue coverage before the child reaches the limiting age and if MDC fails to make the necessary determination by the time the child reaches the limiting age, coverage will continue pending the determination of continued eligibility due to physical or mental disability, injury, illness or condition.

(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.

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.

Nonpayment of Premiums

Member's coverage will be terminated for non-payment 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.

CGP-3-MDC-CA-ELIG-A-08 B850.1086

Option B

INDIVIDUAL CONTINUATION OF BENEFITS

Members may be eligible to retain coverage under this Plan during any Continuation of Coverage period or election period necessary for the 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 Members continue to be paid by or through the Employer pursuant to this Plan.

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to this Plan. The Member must contact the Employer to find out if:

(a) the Employer is subject to the "Federal Continuation Rights" section, and therefore;

(b) the section applies to the Member.

CGP-3-MDC-CA-INCONT-08 B850.1108

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, a "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* of the Employer (b) 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 or any other qualified continuee; and (b) is subject to "When Continuation Ends."

Changes to Benefits or Prepayment Fees

Plan may not decrease any benefits or increase Prepayment Fees as stated in the Group Contract except after a period of at least 30 days from and after the postage paid mailing to *Employer* at Employer's most current address of record with MDC.

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 the *Employee's* 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 his/her *Employer* 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 his/her *Employer* 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 continue; 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 the *Employer* during this extra 11 month continuation period.

If You Die While Insured

If *you* 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 Dependent's group dental benefits end due to his or her loss of Dependent eligibility as defined in this *Plan,* other than Employee's coverage ending, he or she may elect to continue such benefits. But, such Dependent must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends."

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Option B

Concurrent Continuations

If a *Dependent* elects to continue his or her group dental benefits due to: (a) The Employee's termination of employment; or (b) reduction of the Employee's work hours, the *Dependent* may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the *Dependent* becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (ii) the *Employee* 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 *Employer,* in writing, of: (a) your legal divorce or legal separation from your spouse; or (b) the loss of Dependent eligibility, as defined in this *plan,* of a *Dependent.*

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

The 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 dental 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* child.

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 your *Employer* would have paid. Except as explained in "Extra Continuation for Disabled Qualified Continuees," your *Employer* may 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.

When Continuation Ends

A qualified continuee's continued group dental benefits end on the first to occur of:

(a) with respect to continuation upon the Employee's 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 a 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 the Employee's 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 continue; or

(h) the date he or she becomes entitled to Medicare.

CGP-3-MDC-CA-CONT-08 B850.1103

Cal-COBRA

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 the dental benefits of this plan. In this section, these benefits are referred to as "group dental benefits."

Under this section, a "qualified beneficiary" 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* Child of an active covered *Employee.* A child born to, or adopted by, the covered *Employee* during a continuation period is also a qualified beneficiary if the child is enrolled in the Plan as a *Dependent* within 30 days of the child's birth or placement for adoption. Any other person who becomes covered under this Plan during a continuation period provided by this section is not a qualified beneficiary.

A qualified beneficiary will be eligible for continuation coverage without demonstrating evidence of insurability upon certain "qualifying events." "Qualifying events" are defined as: (a) the death of the covered *Employee;* (b) the termination or reduction of work hours of the covered *Employee's* employment, if he or she was not terminated for gross misconduct; (c) the divorce or legal separation of the covered *Employee* from the covered *Employee's* spouse; (d) the loss of Dependent status by a *Dependent* enrolled in the group Plan; and (e) the covered *Employee's* eligibility for coverage under Medicare.

Conversion

Continuing the group health benefits does not stop a qualified beneficiary 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 dental 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 beneficiary; and (b) is subject to "When Continuation Ends."

Extra Continuation for Disabled Qualified Beneficiaries

If a qualified beneficiary 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 the *employee's* 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 beneficiary must give your *Employer* 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; or (b) 60 days after the date the qualified beneficiary is determined to be disabled. If, during this extra 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify *You* 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 the qualified beneficiary by the insurer during this extra 11 month continuation period.

If An Employee Dies While Insured

If *you* die while insured, any qualified beneficiary 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 An Employee's Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified beneficiary 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 *Dependent Child's* group dental 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 beneficiary. The continuation can last for up to 36 months, subject to "When Continuation Ends."

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Option B

Concurrent Continuations

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

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

Special Medicare Rule

If *you* become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for your *Dependents.* The continuation period, after your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months 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 Beneficiary's Responsibilities

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

Such notice must be given to your *Employer* within 60 days of either of these events. Member must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the Employer if the Plan has contracted with the Employer for administrative service, within the 60-day period following the later of (1) the date that the Member's coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the Member was sent notice of that ability to continue coverage under the group benefit plan. A qualified beneficiary electing continuation shall pay to the Plan, in accordance with the terms and conditions of the Plan Contract, which shall set forth in the notice to the qualified beneficiary, the amount of the required premium payment.

Your Employer's Responsibilities

Your *employer* must notify the qualified beneficiary, 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.

Your *Employer* must provide the qualified beneficiary with written notice of the necessary benefit information, premium information, enrollment forms and instructions within 14 days of: (a) the date a qualified beneficiary's group dental benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified beneficiary notifies your *Employer,* in writing, of your legal divorce or legal separation from your spouse, or the loss of Dependent eligibility of a *Dependent* Child.

The Employer's Liability

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

Election of Continuation

To continue his or her group dental benefits, the qualified beneficiary 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 beneficiary receives notice of his or her continuation rights from your *Employer* as described above. And the qualified beneficiary must pay his or her first month's premium within 45 days by first-class mail, certified mail, or other reliable mans of delivery, including personal delivery, express mail, or private courier company, to the Plan, or to the *Employer* if the *Employer* has contracted with the Plan to perform the administrative services. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

The subsequent premiums must be paid to your *Employer,* by the qualified beneficiary, 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 your *Employer* would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," your *Employer* may require an additional charge of 2% of the total premium charge.

If the qualified beneficiary 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 beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary 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.

When Continuation Ends

A qualified beneficiary's continued group dental benefits end on the first of the following to occur:

(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 of the qualifying event:

(b) with respect to a disabled qualified beneficiary 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 of the qualifying event; 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 a final determination is made that a disabled qualified beneficiary 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 of the qualifying event;

(d) with respect to a *Dependent* whose continuation is extended due to the *Employee's* entitlement to Medicare, while the *Dependent* is on continuation, the end of the 36 month period which starts on the date of the qualifying event;

(e) the date your *Employer* ceases to provide any group dental plan to any *Employee;*

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

(g) the date he or she becomes covered under any other group dental plan which does not contain any pre-existing condition exclusion or limitation affecting him or her;

(h) the date he or she becomes entitled to Medicare.

Small Employer Group

Applies to Members who are covered under a Group Contract between MDC and a California small *Employer* group with two (2) through nineteen (19) eligible *Employees.*

You are eligible if you are a permanent *Employee* who is actively engaged on a full-time basis in the conduct of the business of the small *Employer* with a normal workweek of at least 30 hours, at the small Employer s regular places of business, and have met any statutorily authorized applicable waiting period requirements. It also includes any eligible *Employee* who obtains coverage through a guaranteed association. This does not include *Employees* who work on a part-time, temporary, or substitute basis.

Permanent *Employees* who work at least 20 hours but not more than 29 hours are deemed to be eligible *Employees* if all four of the following apply: (1) they otherwise meet the definition of an eligible *Employee* except for the number of hours worked; (2) the *Employer* offers the *Employees* health coverage under a health benefit plan; (3) all similarly situated individuals are offered coverage under the health benefit plan; and (4) the *Employee* must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter.

In order to receive CAL-COBRA benefits for yourself and/or Dependent(s), you or Dependent(s) must provide written notice to MDC within sixty (60) days of the qualifying events, except if coverage terminates due to a reduction of Employee s work hours or termination of your employment. If your coverage and/or coverage for Dependents will terminate due to a reduction of your work hours or termination of your employment, your *Employer* must notify MDC within 30 days of the qualifying event. Notice will be sent to the last know address.

If you or Dependent(s) do not notify MDC within sixty (60) days of the qualifying event(s), you and Dependents(s) will not receive Cal-COBRA benefits. Dependents may also be disqualified from receiving Cal-COBRA benefits if your Employer does not provide MDC with notification as required by law and summarized in the Group Contract.

Within fourteen (14) days of receiving notification of a qualifying event, MDC will mail Cal-COBRA information package to the last known address of the Dependent. The package will contain premium information, enrollment forms and the disclosures necessary to formally elect Cal-COBRA continuation benefits and will be sent to the Dependent s last known address.

If you and/or Dependent(s) are eligible for extended continuation coverage for twenty-nine (29) months as a result of a disability, you and/or Dependent(s) must notify MDC within thirty (30) days of a determination that the Member(s) is no longer disabled.

DENTAL EXPENSE COVERAGE

Managed Dental Care of California - This *Plan's* Dental Coverage Organization

Managed Dental Care of California

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 Dental Care of California network (*MDC* network).

The *MDC* network is made up of *participating dentists* in the *plan's* approved *service area.* A *"participating dentist"* is a *dentist* that has a participation agreement in force with *us.*

When a *Member* enrolls in this *plan,* he or she will get information about *MDC's* current participating general dentists. Each *Member* must be assigned to a *primary care dentist (PCD)* from this list of *participating general dentists.* This *PCD* will coordinate all of the *Member's* dental care covered by this *plan.* After enrollment, a *Member* will receive an *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* is assigned to under this *plan.* What *we* cover is based on all the terms of this *plan.* Read this booklet carefully for specific benefit levels, payment rates, payment limits, conditions, exclusions and limitations and *patient charges.*

You can call the *MDC* Member Services Department if *you* have any questions after reading this booklet.

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Covered Dental Services and Patient Charges 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.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Choice of Dentists

A *Member* may request 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; however, *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 transfer.

MDC compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount each month based upon the number of *Members* that elect them as their PCD.

MDC may also make supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation the *participating general dentist* receives from *MDC.*

The *dentist* also receives compensation from *Members* who may pay an office visit charge for each office visit and a *patient charge* for specific dental services. An office visit charge is a copayment made for each encounter with the PCD and is independent of services rendered. The schedule of *patient charges* is shown in the *Covered Dental Services And Patient Charges* section of this booklet.

Changes In Dentist Participation

We may have to reassign a *Member* to a different *participating dentist* if: (a) the *Member's dentist* is no longer a *participating dentist* in the *MDC* network; or (b) *MDC* takes an administrative action which impacts the *dentist's* participation in the network. If this becomes necessary, the *Member* will have the opportunity to request another *participating dentist.* If a *Member* has a dental service in progress at the time of the reassignment, *we* will, at *our* 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.

Refusal of Recommended Treatment

A *Member* may decide to refuse a course of treatment recommended by his or her PCD or specialty care dentist. The *Member* can request and receive a second opinion by contacting Member Services. If the *Member* still refuses the recommended course of treatment, the PCD or specialty care dentist may have no further responsibility to provide services for the condition involved and the *Member* may be required to select another PCD or specialty care dentist.

Option B

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.

Specialist 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* given in the Covered Dental Services And Patient Charges section. This is the only form of compensation that Participating Specialist receive from *MDC.*

Specialty referral is limited to the following specialties: Endodontic, Oral Surgeons; Orthodontists; Pediatric Dentists; and Periodontists. Additionally, specialist consultants that have not received prior authorization and are for non-covered services are excluded.

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.

In order for specialty services to be covered by this *plan,* the referral process stated below must be followed:

(1) A *member's PCD* must coordinate all dental care.

(2) When the care of a *participating specialty care dentist* is required, the *PCD* must contact *MDC* and request authorization.

(3) If the *PCD's* request for specialty referral is approved, *MDC* will notify the *member.* He or she will be instructed to contact the *participating specialty care dentist* to schedule an appointment.

(4) If the *PCD's* request for specialty referral is denied, the *PCD* and the *member* will receive a written notice along with information on how to appeal the denial to an independent review organization.

(5) If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply to that service, the *PCD* may be asked to perform the service directly, or to provide additional information.

(6) A specialty referral is not a guarantee of covered services. The *plan's* benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a *covered service* in the *plan,* the *member* will be responsible for the entire amount of the *specialist's* charge for that service.

(7) A *member* who receives authorized specialty services must pay 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 specialty care dentist* for treatment. The MDC network includes *participating specialty care dentists* in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the *plan's* approved *service area.* If there is no *participating specialty care dentist* in the *plan's* approved *service area,* MDC will refer the Member to a non-participating specialty care dentist of our choice. Member will only be responsible for the applicable patient charge for services authorized by MDC. In no event will MDC pay for dental care provided to a Member by a specialty care dentist not pre-authorized by MDC to provide such services.

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 *the Member.* 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. However, such material is not required to appeal 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 1-800-292-3330 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, the *Member* will only be responsible for the applicable *patient charge* that would apply if the services were rendered by a contracted specialist. If the *Member* receives a bill from a non-participating specialist for charges other than the applicable *patient charge,* the *Member* 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 submit an appeal through the Grievance Process. This process is shown in the Grievance Process section of this Booklet.

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 *PCD's* available under the Plan Contract are listed in the Network General Dentist booklet. 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. Broken appointment fees will be waived in exigent circumstances (i.e. emergency hospitalization of *Member,* spouse, or child, death of spouse or child).

Member may contact MDC's Member Services Department at (800) 273-3330 to request the Network General Dentist booklet.

Emergency Dental Services

The *MDC* network also provides for *emergency dental services* 24 hours a day, 7 days a week, to all *Members. You* should contact your selected *PCD,* who will arrange for such care.

A *member* may require *emergency dental services* when he or she is unable to obtain services from his or her *PCD.* The *member* should contact his or her PCD for a referral to another dentist or contact MDC for an authorization to obtain services from another dentist. The *member* must submit to *MDC:* (a) the bill incurred as a result of the emergency; (b) evidence of payment; and (c) a brief explanation of the emergency. This should be done within 60 days or as soon as reasonably possible. *MDC* will reimburse the *member* for the cost of covered *emergency dental services,* less the applicable *patient charge(s).*

When *emergency dental services* are provided by a dentist other than the *member's* assigned *PCD,* and without referral by the *PCD* or authorization by *MDC,* coverage is limited to the benefit for palliative treatment (code D9110) only.

Out-of-Area Emergency Dental Services

If you are out of the area, and Emergency Dental Services are required, you should seek palliative treatment from a dentist. You must file a claim within 180 days of service. You must present a detailed statement from the treating dentist, which lists the services provided. MDC will reimburse you within 30 days for any covered Emergency Dental Services, less applicable Patient Charges, up to $50 per incident. This paperwork should be submitted to the address listed on page 1.

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:

Managed Dental Care of California
Quality Management Department
21820 Burbank Boulevard, Suite 200
Woodland Hills CA 91367

Continuity of Care - Terminated Dentist (Cont.)

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.

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.

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MANAGED DENTAL CARE GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison (QCL) who processes the grievances. The QCL can be contacted at 800-273-3330 or by mail to P.O. Box 4391, Woodland Hills, CA 91367, or 21820 Burbank Boulevard, Suite 200, Woodland Hills, CA 91367. The Plan hours are from 8:00 a.m. to 5:00 p.m. Pacific Time.

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, appeals of Specialty Referral decisions, professional and ethical considerations.

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 to complete, if requested. Grievances can also be submitted through the Plan's website www.manageddentalcare.net.

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 documentation.

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.

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 is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL and 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.

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.

8. 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.

9. A Grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.

10. 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.

11. The plan shall keep all copies of grievances, and the responses to grievances, for a period of five years.

12. The Dental Director has primary responsibility for the Plan's grievance system.

13. 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.

14. 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.

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. Grievances requiring expedited review also include, but are not limited to grievances related 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 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 B

COVERED SERVICES

MDC covers diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, fixed prosthodontics, oral surgery, orthodontics and adjunctive general as well as specialist and Emergency Dental Services. Covered services will be provided as necessary for a Member's dental health consistent with professionally recognized standards of practice, subject to the limitations and exclusions described in connection with each category of covered services.

Covered Services include:

DIAGNOSTIC

- Clinical Oral Evaluations
- Radiographs (X-rays)
- Tests and Examinations

* A complete list of covered diagnostic services is listed on the Plan Schedule.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed on the Plan Schedule.

RESTORATIVE

- Amalgam (silver fillings)
- Resin Based Composite (white fillings)
- Inlays
- Onlays
- Crowns
- Other Restorative Services

* A complete list of covered restorative services is listed on the Plan Schedule.

ENDODONTICS

- Pulp Capping
- Pulpotomy
- Endodontic Therapy (root canals)
- Endodontic Retreatment
- Apicoectomy/Periradicular Services

* A complete list of covered endodontic services is listed on the Plan Schedule.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed on the Plan Schedule.

PROSTHODONTICS (Removable)

- Complete Dentures
- Partial Dentures
- Adjustments to Dentures
- Repairs
- Rebase
- Reline

* A complete list of covered prosthodontics (removable) services is listed on the Plan Schedule.

PROSTHODONTICS (Fixed)

- Fixed Partial Denture Pontics
- Fixed Partial Denture Retainers - Crowns

* A complete list of covered prosthodontics (fixed) services is listed on the Plan Schedule.

Note: Treatment which requires the services of a Prosthodontist are not covered.

ORAL SURGERY

- Surgical Extractions
- Other Surgical Procedures
- Alveoloplasty
- Surgical Excision of Intra-Osseous Lesions
- Surgical Incision

* A complete list of covered oral surgery services is listed on the Plan Schedule.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed on the Plan Schedule.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed on the Plan Schedule.

A list of the services covered by this Plan, including Patient Charges is provided in the section called Benefit Schedule.

Exclusions and Limitations will apply to some of the services that apply. Refer to the Principal Exclusions and Limitation of Benefits section of this document.

Covered Dental Services And Patient Charges - Plan U40 M

The services covered by this Plan are named in this list. If a service, treatment or procedure is not on this list, it is not a covered service. All services must be provided by the assigned PCD.

The Member must pay the listed Patient Charge. The benefits We provide are subject to all the terms of this Plan, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services and Exclusions.

The Patient Charges listed in this section are only valid for covered services that are: (1) started and completed under this Plan, and (2) rendered by Participating Dentists in the state of California.

CDT Code	Covered Services and Patient Charges - U40 M Current Dental Terminology (CDT) © American Dental Association (ADA)	Patient Charge
D0999	Office visit during regular hours, general dentist only	$5.00
	EVALUATIONS	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
	RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
	TESTS AND EXAMINATIONS	

D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00

DENTAL PROPHYLAXIS

D1110	Prophylaxis - adult, for the first two services in any 12-month period [1, 2]	$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period [1, 2]	$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period [1, 2]	$60.00

TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)

D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period [1, 3]	$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period [1, 3]	$0.00
D1206	Topical fluoride (prophylaxis not included) - child, for the first two services in any 12-month period [1, 3]	$12.00
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period [1, 3]	$20.00

OTHER PREVENTIVE SERVICES

D1310	Nutritional instruction for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth (molars) [4]	$10.00
D9999	Sealant - per tooth (non-molars) [4]	$35.00

SPACE MAINTENACE (PASSIVE APPLIANCES)

D1510	Space maintainer - fixed - unilateral	$65.00
D1515	Space maintainer - fixed - bilateral	$110.00
D1525	Space maintainer - removable - bilateral	$110.00
D1550	Re-cementation of fixed space maintainer	$15.00
D1555	Removal of fixed space maintainer	$20.00

ALMALGAM RESTORATIONS (INCLUDING POLISHING)

D2140	Amalgam - 1 surface, primary or permanent	$8.00
D2150	Amalgam - 2 surfaces, primary or permanent	$12.00
D2160	Amalgam - 3 surfaces, primary or permanent	$14.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$17.00

RESIN-BASED COMPOSITE RESTORATIONS - DIRECT

D2330	Resin-based composite - 1 surface, anterior	$20.00
D2331	Resin-based composite - 2 surfaces, anterior	$25.00
D2332	Resin-based composite - 3 surfaces, anterior	$30.00

D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$45.00
D2390	Resin-based composite crown, anterior	$50.00
D2391	Resin-based composite - 1 surface, posterior	$35.00
D2392	Resin-based composite - 2 surfaces, posterior	$40.00
D2393	Resin-based composite - 3 or more surfaces, posterior	$45.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$50.00

INLAY/ONLAY RESTORATIONS [6]

D2510	Inlay - metallic - 1 surface [5]	$180.00
D2520	Inlay - metallic - 2 surfaces [5]	$230.00
D2530	Inlay - metallic - 3 or more surfaces [5]	$235.00
D2542	Onlay - metallic - 2 surfaces [5]	$235.00
D2543	Onlay - metallic - 3 surfaces [5]	$240.00
D2544	Onlay - metallic - 4 or more surfaces [5]	$245.00
D2610	Inlay - porcelain/ceramic - 1 surface	$180.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$230.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$235.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$235.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$240.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$245.00

CROWNS - SINGLE RESTORATIONS ONLY [6]

D2740	Crown - porcelain/ceramic substrate	$270.00
D2750	Crown - porcelain fused to high noble metal [5]	$250.00
D2751	Crown - porcelain fused to predominantly base metal	$250.00
D2752	Crown - porcelain fused to noble metal	$250.00
D2780	Crown - 3/4 cast high noble metal [5]	$240.00
D2781	Crown - 3/4 cast predominantly base metal	$240.00
D2782	Crown - 3/4 cast noble metal	$240.00
D2783	Crown - 3/4 porcelain/ceramic	$240.00
D2790	Crown - full cast high noble metal [5]	$250.00
D2791	Crown - full cast predominantly base metal	$250.00
D2792	Crown - full cast noble metal	$250.00
D2794	Crown - titanium	$250.00

OTHER RESTORATIVE SERVICES

D2910	Recement inlay, onlay, or partial coverage restoration	$20.00
D2915	Recement cast or prefabricated post and core	$20.00
D2920	Recement crown	$20.00
D2930	Prefabricated stainless steel crown - primary tooth	$60.00
D2931	Prefabricated stainless steel crown - permanent tooth	$60.00
D2932	Prefabricated resin crown	$90.00
D2933	Prefabricated stainless steel crown with resin window	$90.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$100.00
D2940	Sedative filling	$15.00
D2950	Core buildup, including any pins	$50.00
D2951	Pin retention - per tooth, in addition to restoration	$15.00
D2952	Post & core in addition to crown, indirectly fabricated	$95.00

D2953	Each additional indirectly fabricated post - same tooth	$29.00
D2954	Prefabricated post and core in addition to crown	$85.00
D2957	Each additional prefabricated post - same tooth	$19.00
D2960	Labial veneer (resin laminate) - chairside	$235.00
D2970	Temporary crown (fractured tooth)	$75.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$125.00

PULP CAPPING

D3110	Pulp cap - direct (excluding restoration)	$10.00
D3120	Pulp cap - indirect (excluding restoration)	$10.00

PULPOTOMY

D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$30.00
D3221	Pulpal debridement, primary and permanent teeth	$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$30.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$37.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$40.00

ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)

D3310	Root canal, anterior (excluding final restoration)	$95.00
D3320	Root canal, bicuspid (excluding final restoration)	$160.00
D3330	Root canal, molar (excluding final restoration)	$170.00
D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$95.00
D3333	Internal root repair or perforation defects	$80.00

ENDODONTIC RETREATMENT

D3346	Retreatment of previous root canal therapy - anterior	$310.00
D3347	Retreatment of previous root canal therapy - bicuspid	$370.00
D3348	Retreatment of previous root canal therapy - molar	$445.00

APICOECTOMY/PERIRADICULAR SERVICES

D3410	Apicoectomy/periradicular surgery - anterior	$135.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$145.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$155.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$80.00
D3430	Retrograde filling - per root	$35.00
D3950	Canal preparation and fitting of preformed dowel or post	$20.00

SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)

D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$80.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$45.00
D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$190.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$114.00
D4249	Clinical crown lengthening - hard tissue	$170.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$255.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$155.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$185.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$205.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$225.00

NON-SURGICAL PERIODONTAL SERVICE

D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$30.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$18.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$35.00

OTHER PERIODONTAL SERVICES

D4910	Periodontal maintenance, for the first two services in any 12-month period [1, 2]	$30.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$25.00
D4999	Periodontal maintenance, for each additional service in same 12-month period [1, 2]	$60.00

COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5110	Complete denture - maxillary	$345.00
D5120	Complete denture - mandibular	$345.00
D5130	Immediate denture - maxillary	$345.00
D5140	Immediate denture - mandibular	$345.00

PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)

D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$310.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$310.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$355.00

D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$355.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$430.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$430.00

ADJUSTMENTS TO DENTURES

D5410	Adjust complete denture - maxillary	$20.00
D5411	Adjust complete denture - mandibular	$20.00
D5421	Adjust partial denture - maxillary	$20.00
D5422	Adjust partial denture - mandibular	$20.00

REPAIRS TO COMPLETE DENTURES

D5510	Repair broken complete denture base	$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$35.00

REPAIRS TO PARTIAL DENTURES

D5610	Repair resin denture base	$45.00
D5620	Repair cast framework	$80.00
D5630	Repair or replace broken clasp	$60.00
D5640	Replace broken teeth - per tooth	$35.00
D5650	Add tooth to existing partial denture	$45.00
D5660	Add clasp to existing partial denture	$45.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$160.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$160.00

DENTURE REBASE PROCEDURES

D5710	Rebase complete maxillary denture	$125.00
D5711	Rebase complete mandibular denture	$125.00
D5720	Rebase maxillary partial denture	$125.00
D5721	Rebase mandibular partial denture	$125.00

DENTURE RELINE PROCEDURES

D5730	Reline complete maxillary denture (chairside)	$65.00
D5731	Reline complete mandibular denture (chairside)	$65.00
D5740	Reline maxillary partial denture (chairside)	$65.00
D5741	Reline mandibular partial denture (chairside)	$65.00
D5750	Reline complete maxillary denture (laboratory)	$120.00
D5751	Reline complete mandibular denture (laboratory)	$120.00
D5760	Reline maxillary partial denture (laboratory)	$120.00
D5761	Reline mandibular partial denture (laboratory)	$120.00

INTERIM PROSTHESIS

D5820	Interim partial denture (maxillary)	$95.00

D5821	Interim partial denture (mandibular)	$95.00

OTHER REMOVABLE PROSTHETIC SERVICES

D5850	Tissue conditioning, maxillary	$30.00
D5851	Tissue conditioning, mandibular	$30.00

FIXED PARTIAL DENTURE PONTICS [6]

D6210	Pontic - cast high noble metal [5]	$230.00
D6211	Pontic - cast predomniantly base metal	$230.00
D6212	Pontic - cast noble metal	$230.00
D6214	Pontic - titanium	$230.00
D6240	Pontic - porcelain fused to high noble metal [5]	$230.00
D6241	Pontic - porcelain fused to predominantly base metal	$230.00
D6242	Pontic - porcelain fused to noble metal	$230.00
D6245	Pontic - porcelain/ceramic	$240.00

FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS [6]

D6600	Inlay - porcelain/ceramic, - 2 surface	$230.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$235.00
D6602	Inlay - cast high noble metal, - 2 surfaces [5]	$230.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces [5]	$235.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$230.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$235.00
D6606	Inlay - cast noble metal, 2 surfaces	$230.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$235.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$235.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$240.00
D6610	Onlay - cast high noble metal, 2 surfaces [5]	$235.00
D6611	Onlay - cast high noble metal, 3 or more surfaces [5]	$240.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$235.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$240.00
D6614	Onlay - cast noble metal, 2 surfaces	$235.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$240.00
D6624	Inlay - titanium	$230.00
D6634	Onlay - titanium	$235.00

FIXED PARTIAL DENTURE RETAINERS - CROWNS [6]

D6740	Crown - porcelain/ceramic	$270.00
D6750	Crown - porcelain fused to high noble metal [5]	$250.00
D6751	Crown - porcelain fused to predominantly base metal	$250.00
D6752	Crown - porcelain fused to noble metal	$250.00
D6780	Crown - 3/4 cast high noble metal [5]	$240.00
D6781	Crown - 3/4 cast predominantly base metal	$240.00
D6782	Crown - 3/4 cast noble metal	$240.00
D6783	Crown - 3/4 porcelain/ceramic	$240.00
D6790	Crown - full cast high noble metal [5]	$250.00
D6791	Crown - full cast predominantly base metal	$250.00
D6792	Crown - full cast noble metal	$250.00
D6794	Crown - titanium	$250.00

OTHER FIXED PARTIAL DENTURE SERVICES

D6930	Recement fixed partial denture	$15.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$95.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$85.00
D6973	Core buildup for retainer, including any pins	$55.00
D6976	Each additional cast post - same tooth	$29.00
D6977	Each additional prefabricated post - same tooth	$19.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment [6]	$125.00

EXTRACTIONS

D7111	Extraction, coronal remnants - deciduous tooth	$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$10.00

SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)

D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$30.00
D7220	Removal of impacted tooth - soft tissue	$50.00
D7230	Removal of impacted tooth - partially bony	$70.00
D7240	Removal of impacted tooth - completely bony	$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$90.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$35.00
D7261	Primary closure of a sinus perforation	$250.00

OTHER SURGICAL PROCEDURES

D7280	Surgical access of an unerupted tooth	$130.00
D7283	Placement of device to facilitate eruption of impacted tooth	$40.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$70.00
D7286	Biopsy of oral tissue - soft	$65.00
D7288	Brush biopsy - transepithelial sample collection	$65.00

ALEVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES

D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$50.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$25.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$70.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	$49.00

SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS

D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$85.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$160.00

EXCISION OF BONE TISSUE

D7471	Removal of lateral exostosis (maxilla or mandible)	$125.00
D7472	Removal of torus palatinus	$125.00
D7473	Removal of torus mandibularis	$125.00

SURGICAL INCISION

D7510	Incision and drainage of abscess - intraoral soft tissue	$40.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$44.00

OTHER REPAIR PROCEDURES

D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$95.00
D7963	Frenuloplasty	$152.00

UNCLASSIFIED TREATMENT

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$15.00
D9120	Fixed partial denture sectioning	$10.00
D9215	Local anesthesia	$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes [7]	$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes [7]	$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes [7]	$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes [7]	$75.00

PROFESSIONAL CONSULTATION

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$30.00

PROFESSIONAL VISITS

D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00

MISCELLANEOUS SERVICES

D9951	Occlusal adjustment - limited	$20.00
D9971	Odontoplasty, 1-2 teeth	$20.00
D9972	External bleaching - per arch	$165.00

Broken Appointment $25.00

[1] The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first 2 services in any 12-month period. For each additional services in the same 12-month period, see codes D1999, D2999 and D4999 for the applicable Patient Charge.

[2] Routine prophylaxis or periodontal maintenance procedure - a total of 4 services in any 12-month period. One of the covered periodontal maintenance procedures may be performed by a *participating periodontal specialty care dentist* if done within 3 to 6 months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a *participating periodontal specialty care dentist.* Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.

[3] Fluoride treatment - a total of 4 services in any 12- month period.

[4] Sealants are limited to permanent teeth up to the 16th birthday.

[5] If high noble metal is used, there will be an additional Patient Charge for the actual cost of the high noble metal.

[6] The *patient charge* for these services is per unit.

[7] Procedure codes D9220, D9221, D9241 and D9242 are limited to a *participating specialty care oral surgeon.* Additionally, these services are only covered in conjunction with other covered surgical services.

Option B

Covered Dental Services And Patient Charges - Plan U40 M

CDT Code	Covered Services and Patient Charges - U40 M Current Dental Terminology (CDT) © American Dental Association (ADA)	Patient Charge
	ORTHODONTICS [8, 10]	
D8070	Comprehensive orthodontic treatment of the transitional dentition [9, 11]	Child: $1500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition [9, 11]	Child: $1500.00
D8090	Comprehensive orthodontic treatment of the adult dentition [9, 11]	Adult: $2800.00
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention	$400.00
	Broken Appointment	$25.00

[8] The orthodontic *patient charges* are valid for authorized services started and completed under this Plan and rendered by a *participating orthodontic specialty care dentist* in the state of California.

[9] Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above, employee or spouse. A *member's* age is determined on the date of banding.

[10] Limited to one course of comprehensive orthodontic treatment per *member.*

[11] Comprehensive orthodontic treatment is limited to 24 months of continuous treatment.

Option B

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 *member* selects a posterior composite restoration as an alternative procedure to a recommended amalgam restoration, the *alternative procedure* policy does not apply.

When the *member* selects an extraction, the *alternative procedure* policy does not apply.

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 *plan* provides for the use of noble, high noble and base metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, *the member* will pay an additional amount for the actual cost of the high noble metal. In addition, *the member* will pay the usual *patient charge* for the inlay, onlay, crown or fixed bridge. The total *patient charges* for high noble metal may not exceed the actual lab bill for the service.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *member* with a treatment *plan* in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

General Guidelines For Alternative Treatment By The PCD

There may be a number of accepted methods for treating a specific dental condition. In all cases where there are more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins, to minimize the potential for confusion over what the *member* should pay, and to fully document informed consent.

- If any of the recommended alternate services are selected by the *member* and not covered under the *plan,* then the *member* must pay the *PCD's* usual charge for the recommended alternate service.
- If any treatment is specifically not recommended by the *PCD* (i.e., the *PCD* determines it is not an appropriate service for the condition being treated), then the *PCD* is not obliged to provide that treatment even if it is a covered service under the *plan.*
- *Members* can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the *PCD or Specialty Care Dentist.*

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.* Immediate dentures are not subject to the 5-year limitation.

The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6 months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture.

Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the *PCD.*

Multiple Crown/Bridge Unit Treatment Fee

When a *member's* treatment plan includes six (6) or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the *member* will be responsible for the *patient charge* for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

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Option B

Pediatric Specialty Services

If, during a *PCD* visit, a *member* under age eight (8) is unmanageable, the *PCD* may refer the *member* to a *Participating Pediatric Specialty Care Dentist* for the current treatment plan only. Following completion of the approved pediatric treatment plan, the *member* must return to the *PCD* for further services. If necessary, *we* must first authorize subsequent referrals to the *participating specialty care dentist.* Any services performed by a *Pediatric Specialty Care Dentist* after the *member's* eighth birthday will not be covered, and the *member* will be responsible for the *Pediatric Specialty Care Dentist's* usual fees.

Second Opinion

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.*

Plan will review and approve second opinions if there are questions regarding the following:

- The reasonableness or necessity of a recommended surgical procedure.
- Diagnosis or plan of care, including once care has been initiated.
- Treatment in progress.
- Authorization or denial will be provided in an expeditious manner. *Member* will be notified in writing if the second opinion is denied and reason for denial will be included. *Member* will have the right to file a grievance with the Plan. The grievance process is located in this booklet.
- The second opinion consultation will be provided by an MDC Participating Dentist of the *Member's* choice. *Member* is responsible for office visit Patient Charge.

A Member Services Representative will help *you* identify a *Participating Dentist* to perform the second opinion consultation. *The member* 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.* Authorizations for second opinions are valid for sixty (60) days from the date of approval. 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.

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. Second opinions that have not received prior authorization and are for non-covered services are excluded.

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, the member will be responsible for the patient charge for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

General Anesthesia / IV Sedation

General anesthesia / IV sedation - General anesthesia or IV sedation is limited to services provided by a Participating Oral Surgery Specialty Care Dentist. Not all Participating Oral Surgery Specialty Care Dentists offer these services. The member is responsible to identify and receive services from a Participating Oral Surgery Specialty Care Dentist willing to provide general anesthesia or IV sedation. The member's patient charge is shown in the Covered Dental Services Patient Charge Section.

Office Visit Charges

Office visit patient charges that are the member's responsibility after the employer's group plan has been in effect for three full years, will be paid to the PCD by us.

Option B

Orthodontic Treatment

The *plan* covers orthodontic services as shown in the Covered Dental Services and Patient Charges section. Coverage is limited to one course of treatment per *member. We* must preauthorize treatment, and treatment must be performed by a *Participating Orthodontic Specialty Care Dentist.*

The *plan* covers up to twenty-four (24) months of comprehensive orthodontic treatment. If treatment beyond twenty-four (24) months is necessary, the *member* will be responsible for an additional charge for each additional month of treatment, based upon the participating Orthodontic Specialty Care Dentist's contracted fee.

Except as described under Treatment in Progress-Orthodontic Treatment and Orthodontic Takeover Treatment In-Progress Sections, orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the *plan.* If a *member's* coverage terminates after the fixed banding appliances are inserted, the *Participating Orthodontic Specialty Care Dentist* may prorate his or her usual fee over the remaining months of treatment. Retention services are covered at the Patient Charge shown in the Plan Schedule's section only following a course of comprehensive orthodontic treatment started and completed under this *plan.*

If a *member* transfers to another *Orthodontic Specialty Care Dentist* after authorized comprehensive orthodontic treatment has started under this *plan,* the *member* will be responsible for any additional costs associated with the change in *Orthodontic Specialty Care Dentist* and subsequent treatment.

The benefit 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. Additional fixed or removable appliances will be the *member's* responsibility. The benefit for orthodontic retention is limited to twelve (12) months and covers any and all necessary fixed and removable appliances and 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 non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the *member's* responsibility.

If a *member* has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the *plan* provides the standard orthodontic benefit. The *member* will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the *Participating Orthodontic Specialist Dentist's* usual fee.

Option B

Treatment In Progress

A *member* may choose to have a *participating dentist* complete an inlay, onlay, crown, fixed bridge, denture, root canal, or orthodontic treatment procedure which: (1) is listed in the *Covered Dental Services and Patient Charges* Section; and (2) was started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* The *member* is responsible to identify, and transfer to, a *participating dentist* willing to complete the procedure at the *patient charge* described in this section.

- Restorative Treatment - Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are listed as covered services and were started but not completed prior to the *member's* eligibility to receive benefits under this *plan,* have a patient charge equal to 85% of the *Participating General Dentist's* usual fee. (There is no additional charge for high noble metal.)

- Endodontic Treatment - Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are listed on the Member's Plan Schedule that were started but not completed prior to the *member's* eligibility to receive benefits under this *plan* may be covered if the *member* identifies a *Participating General or Specialty Care Dentist* who is willing to complete the procedure at a patient charge equal to 85% of *Participating Dentist's* usual fee.

- Orthodontic Treatment - Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are listed on the Covered Dental Services and Patient Charges section and were started but not completed prior to the *member's* eligibility to receive benefits under this *plan* may be covered if the *member* identifies a *Participating Orthodontic Specialty Care Dentist* who is willing to complete the Treatment, including retention, at a *patient charge* equal to 85% of the *Participating Orthodontic Specialty Care Dentist's* usual fee. Also refer to the Orthodontic Takeover Treatment-In-Progress Section.

Takeover Benefit for Orthodontic Treatment

The Treatment in Progress - Takeover Benefit for Orthodontic Treatment provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another dental HMO plan with the current treating orthodontist, after This Plan becomes effective.

A Member may be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment only if:

- the Member was covered by another dental HMO plan just prior to the effective date of This Plan and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with a participating network orthodontist under the prior dental HMO plan;

- the Member has such orthodontic treatment in progress at the time This Plan becomes effective;

- the Member continues such orthodontic treatment with the treating orthodontist;

- the Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental HMO plan; and
- a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form, completed by the treating orthodontist, is submitted to us within 6 months of the effective date of This Plan.

The benefit amount will be calculated based on: (i) the number of remaining months of comprehensive orthodontic treatment; and (ii) the amount by which the Member's payment responsibility has increased as a result of the treating orthodontist's raised fees, up to a maximum benefit of $500 per Member.

The Member will be responsible to have the treating orthodontist complete a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form and submit it to Us. The Member has 6 months from the effective date of This Plan to have the Form submitted to Us in order to be eligible for the Orthodontic Takeover Treatment-In-Progress Benefit. We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under This Plan is terminated.

This benefit is only available to Members that were covered under the prior dental HMO plan and are in comprehensive orthodontic treatment with a participating network orthodontist when This Plan becomes effective with Us. It will not apply is the comprehensive orthodontic treatment was started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another orthodontist. This benefit applies to Members of new Plans only. It does not apply to Members of existing Plans. And it does not apply to persons who become newly eligible under the Group after the effective date of This Plan.

The benefit is only available to Members in comprehensive orthodontic treatment (D8070, D8080, D8090). It does not apply to any other orthodontic services. Additionally, we will only cover up to a total of 24 months of comprehensive orthodontic treatment.

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Option B

Limitations on Benefits For Specific Covered Services

NOTE: Time limitations for a service are determined from the date that service was last rendered under this *plan.*

The codes below in parentheses refer to the CDT Codes as shown in the Covered Dental Services and Patient Charges section.

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) - a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a *Participating Periodontal Specialty Care Dentist* if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a *Participating Periodontal Specialty Care Dentist.* Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride Treatment (D1203, D1204, D1206, D2999) - Four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to one (1) in any two (2) year period on or after the 40th birthday.
- Full mouth x-rays - one (1) set in any three (3) year period.
- Bitewing x-rays - two (2) sets in any twelve (12) month period.
- Panoramic x-rays - one (1) set in any three (3) year period.
- Sealants - limited to permanent teeth, up to the 16th birthday - one (1) per tooth in any three (3) year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) - a total of one (1) service per quadrant or area in any three (3) year period.
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) - a total of one (1) service per area in any three (3) year period.
- Periodontal scaling and root planing (D4341, D4342) - one (1) service per quadrant or area in any twelve (12) month period.
- Emergency dental services when more than 50 miles from the *PCD s* office - limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the *member s* assigned *PCD,* and without referral by the *PCD* or authorization by *MDC* - limited to the benefit for palliative treatment (code D9110) only.
- Reline of a complete or partial denture - one (1) per denture in twelve (12) month period.
- Rebase of a complete or partial denture - one (1) per denture in any twelve (12) month period.
- Second Opinion Consultation - when approved by us, a second opinion consultation will be reimbursed up to $50.00 per treatment plan. The office visit patient charge will apply.

Option B

Exclusions

We won't cover:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise Covered Service involving (a) congenitally missing or (b) supernumerary teeth.
- Any *histopathological* examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatment or appliances requested, recommended or performed: (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) intramuscular sedation, (b) oral sedation, or (c) 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 lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the negligence of the member.
- Any *member* request for: (a) specialist services or treatment which can be routinely provided by the *PCD,* or (b) treatment by a specialist without a referral from the *PCD* and approval from *us.*
- Treatment provided by any public program, 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 (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the *temporomandibular joint (TMJ).*
- Dental services, other than covered *Emergency Dental Services,* which were performed by any *dentist* other than the *member's* assigned *PCD,* unless *we* had provided written authorization.
- 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 Specialty Care Dentist,* after the *member's* 8th birthday.
- Consultations for non-covered services.
- Any procedure not specifically listed in the Covered Dental Services and Patient Charges Section.

CGP-3-MDC-CA-EXCL-08 B850.1023

Option B

- 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 or dentures started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Restorative Treatment. (Inlays, onlays crowns or fixed bridges are (a) considered to be started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are (a) considered to be started when the impressions are taken, and (b) completed when the denture is delivered to the *member.)*
- Root canal treatment started, but not completed, prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Endodontic Treatment. (Root canal treatment is: considered to be (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)
- Orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Orthodontic Treatment. (Orthodontic treatment is considered to be started when the teeth are banded.)

- Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the *plan* as *Emergency Dental Services.*
- *Root canal* treatment started by a *non-participating dentist. (Root canal* treatment is considered to be started when the pulp chamber is opened). This exclusion will not apply to services that were started and which were covered, under the *plan* as *Emergency Dental Services.*
- Orthodontic treatment started by a non-participating dentist while the Member is covered under This Plan. (Orthodontic treatment is considered to be started when the teeth are banded.)
- 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 (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening (D4249) performed in the presence of *periodontal* disease on the same tooth.
- Procedures performed to facilitate non-covered services, including but not limited to: (a) *root canal* therapy to facilitate *overdentures, hemisection* or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices: (a) 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.*

Option B

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 B

Advertisement means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of Plan Contracts.

CGP-3-MDC-CA-GLS-08 B850.1088

Option B

Code means the California Health and Safety Code.

CGP-3-MDC-CA-GLS-08 B850.1089

Option B

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 B

Coordination of Benefits means the method by which a health care service plan contract, covering dental services of a specialized health care service plan contract, covering dental services, and one or more other health care service plans, specialized health care service plans, or disability insurers, covering dental services, pay their respective reimbursements for dental benefits when an enrollee is covered by multiple health care service plans or specialized health care service plan contracts, or a combination thereof, or a combination of health care service plans or specialized health care service plan contracts and disability insurers.

CGP-3-MDC-CA-GLS-08 B850.1090

Option B

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 B

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 B

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 B

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 B

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 B

Evidence of Coverage means any certificate, agreement, contract, brochure, or letter of entitlement issued to a Subscriber or Member setting forth the coverage to which they are entitled.

CGP-3-MDC-CA-GLS-08 B850.1110

Option B

Exclusions means those services or conditions that are not intended to be covered by the Plan. Services not specifically listed on the Benefit Schedule are not covered.

CGP-3-MDC-CA-GLS-08 B850.1091

Option B

Facility means (1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of a Plan or any affiliate thereof, and (2) any premises maintained by a provider to provide services on behalf of a Plan.

CGP-3-MDC-CA-GLS-08 B850.1092

Option B

Group Contract and Plan Contract means a contract, which by its terms limits the eligibility of subscribers and enrollees to a specified group.

CGP-3-MDC-CA-GLS-08 B850.1093

Option B

Limitations means restrictive conditions stated in a dental benefit contract, such as age, length of time covered and waiting periods that affect an individual's or group's coverage. Limitations may be based on frequency, age, time periods for replacement of a service (i.e. life expectancy of a service), time periods for treatment (e.g., comprehensive orthodontic treatment), waiting periods, and annual or lifetime payment amounts.

CGP-3-MDC-CA-GLS-08 B850.1094

Option B

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 B

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 B

Other Party means the group representative designated in the Plan Contract.

CGP-3-MDC-CA-GLS-08 B850.1095

Option B

Participating Dentist means a *dentist* under contract with MDC.

CGP-3-MDCD10 B850.0829

Option B

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 B

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 B

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 and is paid to the treating dentist at the time services are rendered.

CGP-3-MDC-CA-GLS-08 B850.1100

Option B

Plan means the MDC group *plan* for dental services described in this booklet.

CGP-3-MDCD14 B850.0223

Option B

Primary Care Dentist (PCD) means a Participating General Dentist who provides *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-MDC-CA-GLS-08 B850.1101

Option B

Service Area means the geographic area in which MDC is licensed to provide dental services for *members.*

CGP-3-MDCD16 B850.0225

Option B

Solicitation means any presentation or advertising conducted by, or on behalf of, a Plan, where information regarding the Plan, or Services offered and charges therefore, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the Plan.

CGP-3-MDC-CA-GLS-08 B850.1096

Option B

Specialized Health Care Service Plan means any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribes or enrollees.

CGP-3-MDC-CA-GLS-08 B850.1097

Option B

Specialized Health Care Service Plan Contract means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

CGP-3-MDC-CA-GLS-08 B850.1098

Option B

Utilization Review means the process that includes prospective, retrospective and/or concurrent review of dental care and which approves, modifies, or denies benefits for care, based on whole or in part on medical necessity.

CGP-3-MDC-CA-GLS-08 B850.1099

Option B

We, Us, Our and MDC mean Managed Dental Care of California.

CGP-3-MDCD17 B850.0226

Option B

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.

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 primary, MDC will pay the maximum amount required by its contract or policy with the Member when coordinating benefits with a secondary dental benefit plan.

When MDC is secondary, MDC will pay the lesser of either the amount that we would have paid in the absence of any other dental benefit coverage or the Member's total out-of-pocket cost under the primary dental benefit plan for benefits covered under the secondary dental benefit plan.

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 Medicad, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

CGP-3-MDC-COB-08 B850.1111

Option B

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 Employers 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 Members entry into active military duty. But, coverage will not end if the Members 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.

Candee Bolyog
President, Managed Dental Care

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 U40	**Deductibles**	**Lifetime Maximums**	**Professional Services**			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Bitewings 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 - $60; Flouride - $0 - $20; Sealants - $10 - $35; Space Maintainers - $65 - $110	Amalgam - $8 - $17; Resin - $20 - $50; Crowns - $240 - $270; Inlays & Onlays - $180 - $245; Labial Veneer - $235; Miscellaneous Restorative Services - $15 - $125	Pulp Cap - $10; Pulpotomy - $30 - $40; Root Canals - $95 - $170; Retreatments - $310 - $445; Apicoectomy - First Root - $135 - $155; Each Additional Root - $80; Retrograde Filling - Per Root - $35; Canal Preparation - $20

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)

U40 (Cont.)	**Deductibles**	**Lifetime Maximums**	**Professional Services (Continued)**			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member	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 Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, 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	

MDC U40 0308

B850.1056

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)

U40 (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 Excision Of Bone Tissue	Comprehensive Treatment; Retention; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia General Anesthesia Intravenous Conscious Sedation/ Analgesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - $45 - $80; Gingival Flap Procedure - $114 - $190; Osseous Surgery - $155 - $255; Scaling & Root Planing - $18 - $30; Soft Tissue Graft - $185 - $225; Crown Lengthening - $170; Miscellaneous Periodontal Services - $25 - $30	Complete Denture - $345; Immediate Denture - $345; Rebase - $125; Interim Partial - $95; Partial Denture - $310 - $430; Reline - $65 - $120; Repair - $35 - $160; Tissue Conditioning - $30; Denture Adjustment - $20	Extractions - Coronal Total/ Remnants/ Erupted Exposed Root - $10; Surgical Removal - $30; Removal Of Impacted Tooth - $50 - $90; Alveoloplasty - $25 - $70; Removal of Cyst/ Tumor - $85 - $160; Excision Of Bone Tissue - $125; Surgical Incision - $40 - $44; Other Surgical Procedures - $40 -$130; Other Repair Procedures - $95 - $152;	To Age 18 - $1500; Over Age 18 - $2800; Retention - $400; Treatment Plan And Records - $250.00	Office Visit - $0 - $10; After Hours Office Visit - $50; Palliative Treatment - $15; Local Anesthesia - $0; General Anesthesia/ Conscious Sedation - $75 - $95; External Bleaching - $165; Miscellaneous Services - $0 - $34

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)

U40 (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; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

B850.1060

THIS IS A REVISED UNIFORM MATIRX 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.

MDC U40 0308

B850.1058

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)

U40 (Cont.)	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*

U40 (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.

MDC U40 0308

B850.1059

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.

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 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.

- 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.

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.

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All Options

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

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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

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