YOUR GROUP INSURANCE PLAN BENEFITS

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

The Guardian
7 Hanover Square
New York, New York 10004

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

<table>
<thead>
<tr>
<th>Group Policy No.</th>
<th>Certificate No.</th>
<th>Effective Date</th>
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<tbody>
<tr>
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</tbody>
</table>

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.

Vice President, Group Products

CGP-3-R-STK-90-3

B110.0023
# TABLE OF CONTENTS

**COMPLAINT NOTICE** ................................................................. 1

**GENERAL PROVISIONS**
- Limitation of Authority ...................................................... 3
- Incontestability ................................................................. 3
- Accident and Health Claims Provisions .................................. 4
- An Important Notice About Continuation Rights ..................... 5

**YOUR CONTINUATION RIGHTS**
- Federal Continuation Rights .................................................. 6
- Uniformed Services Continuation Rights ................................ 10
- Dependent Spouse Continuation Rights .................................. 10
- Dependent Child Continuation Rights .................................... 13

**ELIGIBILITY FOR DENTAL COVERAGE**
- Employee Coverage ............................................................. 16
- Dependent Coverage ........................................................... 17

**CERTIFICATE AMENDMENT** ..................................................... 21

**DENTAL HIGHLIGHTS** ............................................................ 23

**DENTAL EXPENSE INSURANCE**
- DentalGuard Preferred - This Plan’s Dental .......................... 24
- Preferred Provider Organization ............................................ 24
- Covered Charges ................................................................. 24
- Alternate Treatment ............................................................ 25
- Proof Of Claim ................................................................. 25
- Pre-Treatment Review ........................................................ 26
- Benefits From Other Sources ................................................. 26
- The Benefit Provision - Qualifying For Benefits .................... 26
- Rollover of Benefit Year Payment Limit for ......................... 28
- Group I, II and III Non-Orthodontic Services ....................... 30
- After This Insurance Ends .................................................... 30
- Special Limitations ............................................................. 31
- Exclusions ........................................................................... 31
- List of Covered Dental Services ........................................... 34
- Group I - Preventive Dental Services .................................... 34
- Group II - Basic Dental Services .......................................... 35
- Group III - Major Dental Services ........................................ 39

**DISCOUNT - THIS IS NOT INSURANCE**
- Discounts on Dental Services Not Covered By This Plan ........... 42

**THIS IS NOT INSURANCE**
- Discounts on Dental Supplies Not Covered By This Plan .......... 43
- Discounts on Services Not Covered Due To ......................... 43
- Contractual Provisions ......................................................... 43
- Discounts on Orthodontic Services ...................................... 43

**ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE**
- Employee Vision Care Expense Coverage .............................. 45
- Dependent Vision Care Expense Coverage ............................. 46
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERTIFICATE AMENDMENT</td>
<td>50</td>
</tr>
<tr>
<td>VISION CARE HIGHLIGHTS</td>
<td>52</td>
</tr>
<tr>
<td>VISION CARE EXPENSE INSURANCE</td>
<td></td>
</tr>
<tr>
<td>Vision Service Plan -</td>
<td></td>
</tr>
<tr>
<td>This Plan's Vision Care Preferred Provider Organization</td>
<td>53</td>
</tr>
<tr>
<td>How This Plan Works</td>
<td>55</td>
</tr>
<tr>
<td>Services or Supplies From a Preferred Provider</td>
<td>55</td>
</tr>
<tr>
<td>Services or Supplies From a Non-Preferred Provider</td>
<td>56</td>
</tr>
<tr>
<td>Covered Charges</td>
<td>57</td>
</tr>
<tr>
<td>Covered Services and Supplies</td>
<td>57</td>
</tr>
<tr>
<td>Special Limitations</td>
<td>59</td>
</tr>
<tr>
<td>Exclusions</td>
<td>59</td>
</tr>
<tr>
<td>COORDINATION OF BENEFITS</td>
<td></td>
</tr>
<tr>
<td>Definitions</td>
<td>61</td>
</tr>
<tr>
<td>Order Of Benefit Determination</td>
<td>63</td>
</tr>
<tr>
<td>Effect On The Benefits Of This Plan</td>
<td>65</td>
</tr>
<tr>
<td>Right To Receive And Release Needed Information</td>
<td>65</td>
</tr>
<tr>
<td>Facility Of Payment</td>
<td>65</td>
</tr>
<tr>
<td>Right Of Recovery</td>
<td>65</td>
</tr>
<tr>
<td>WORKER'S COMPENSATION</td>
<td>66</td>
</tr>
<tr>
<td>CERTIFICATE AMENDMENT</td>
<td>67</td>
</tr>
<tr>
<td>GLOSSARY</td>
<td>68</td>
</tr>
<tr>
<td>STATEMENT OF ERISA RIGHTS</td>
<td></td>
</tr>
<tr>
<td>The Guardian’s Responsibilities</td>
<td>75</td>
</tr>
<tr>
<td>Group Health Benefits Claims Procedure</td>
<td>76</td>
</tr>
<tr>
<td>Termination of This Group Plan</td>
<td>80</td>
</tr>
</tbody>
</table>
COMPLAINT NOTICE

This notice is to advise you that should any complaints arise regarding this insurance you may contact the following:

The Guardian Sales Office
550 West Jackson Blvd., 18th Floor
Chicago, Illinois 60661
Telephone: (312) 993-1000
(800) 933-3136
Fax: (312) 993-3454

* * * * *

Illinois Department of Insurance
Consumer Division or Public Services Section
Springfield, Illinois 62767

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PREFERRED PROVIDERS ARE USED

You should be aware that when you elect to utilize the services of a non-preferred provider for a covered treatment in non-emergency situations, benefit payments to such non-preferred provider are not based upon the amount billed. The basis of your benefit payment will be determined according to your plan’s reasonable and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the plan. YOU CAN EXPECT TO PAY MORE THAN THE PAYMENT RATE DEFINED IN THE PLAN AFTER THE PLAN HAS PAID ITS REQUIRED PORTION. Non-preferred providers may bill for any amount up to the billed charge after the plan has paid its portion of the bill. Preferred providers have agreed to accept discounted payments for services with no additional billing other than payment rate and deductible amounts. You may obtain further information about the participating status of professional providers and information on out-of-pocket expenses by calling the toll free telephone number on your identification card.

CGP-3-ILDISC B120.0007

CGP-3-PPODI-IL-02 B120.0060
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.

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.

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 or an employee in a signed application for up to two years from the effective date of this plan.
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.
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
Federal Continuation Rights

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

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

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

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

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

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

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

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

This extra 11 month continuation is subject to "When Continuation Ends".
Federal Continuation Rights (Cont.)

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

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

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.
Federal Continuation Rights (Cont.)

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.

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.
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.

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.

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;
Federal Continuation Rights (Cont.)

(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.

Dependent Spouse Continuation Rights

Important Notice

This section applies only to any hospital, surgical, medical, major medical, prescription drug, and dental expense coverages as that are provided by this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to coverages which provide benefits for loss of life or loss of income due to disability. These coverages, if provided, cannot be continued under this section.

Any continuation of group health benefits under this section will be subject to all of the terms and conditions of this plan.

If an employee’s marriage ends by legal divorce or annulment, or if an employee dies while covered, his or her then covered spouse may continue this plan’s group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the employee’s former spouse and those of the employee’s dependent children whose group health benefits would otherwise end.
If an employee retires while covered, his or her then covered spouse who is age 55 or older at that time may continue this plan’s group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the retired employee’s spouse and those of the retired employee’s dependent children whose group health benefits would otherwise end.

How And When To Continue The Group Health Benefits

To continue the group health benefits, the employee’s former spouse or retired employee’s spouse must: (a) be covered for group health benefits under this plan at the time the marriage ends or the employee dies or retires; (b) in the case of a retired employee’s spouse, be age 55 or older at the time the employee retires; (c) give written notice to Guardian or the employer of the end of the marriage or the death or retirement of the employee within 30 days after such event occurs; and (d) elect to continue the group health benefits and pay the first monthly premium as described below.

If the employee’s former spouse or retired employee’s spouse fails to elect to continue group health benefits, and/or fails to pay the first monthly premium, within 30 days after the date he or she receives the notice described below, group health benefits will end, and he or she waives the right to continue group health benefits under this plan.

The Employer’s Responsibility

The employer must give written notice to Guardian within 15 days of the date of receipt of written notice from the employee’s spouse of the end of the marriage or the death or retirement of the employee. The employer’s notice must include the former spouse’s or retired employee’s spouse’s place of residence. The employer must also send, at the same time, a copy of such notice to the employee’s former spouse or retired employee’s spouse at the employee’s former spouse’s or retired employee’s spouse’s place of residence.

Guardian’s Responsibility

Within 30 days after the date of receipt of written notice from the employer, employee’s former spouse or retired employee’s spouse of the end of the marriage or the death or retirement of the employee, Guardian will notify the employee’s former spouse or retired employee’s spouse of his or her right to continue group health benefits for him or her and those of the employee’s or retired employee’s dependent children whose group health benefits would otherwise end.

Guardian’s notice will be sent by certified mail, return receipt requested to the former spouse’s or retired employee’s spouse’s place of residence. This notice will include: (a) a form for electing to continue group health benefits; (b) the amount of periodic premiums to be charged to continue group health benefits, and the method and place of payment; and (c) instructions for returning the election form within 30 days after the date it is received.

If Guardian fails to give notice as required above, all premiums for continued group health benefits will be waived from the date notice was required until the date notice is sent. Except as stated below, group health benefits will continue under the terms and conditions of this plan from the date notice was required until the date notice is sent. This will not apply where the group health benefits that exist at the time the notice was to be sent are ended for all employees or the class of employees to which the employee, deceased employee, or retired employee belongs.
Dependent Spouse Continuation Rights (Cont.)

**Premiums**

The monthly premium for continued group health benefits will be computed as follows:

1. With respect to a former spouse who has not reached the age of 55 at the time continued group health benefits start: (a) an amount, if any, that would be charged an employee if the former spouse were a current employee of the employer; plus (b) an amount, if any, that the employer would contribute toward the premium if the former spouse were a current employee.

2. With respect to a retired employee’s spouse or former spouse who has reached the age of 55 at the time continued group health benefits start:
   
   (a) For each month during the first two years of continued group health benefits: (i) an amount, if any, that would be charged an employee if the retired employee’s spouse or the former spouse were a current employee of the employer; plus (ii) an amount, if any, that the employer would contribute toward the premium if the retired employee’s spouse or the former spouse were a current employee.

   (b) Starting two years after continued group health benefits start: (i) an amount, if any, that would be charged an employee if the retired employee’s spouse or the former spouse were a current employee of the employer; plus (ii) an amount, if any, that the employer would contribute toward the premium if the retired employee’s spouse or the former spouse were a current employee; plus (iii) an additional amount, not to exceed 20% of the total of the amounts determined by (i) and (ii), for costs of administration.

**When Continued Group Health Benefits End**

Continued group health benefits end for each covered person on the first to occur of the following:

1. With respect to a former spouse who has not reached the age of 55 at the time continued group health benefits start: (a) the end of the period for which the last premium payment was made; (b) the date the person becomes covered for similar benefits under another group plan; (c) the date the former spouse remarries; (d) with respect to each person, the date such person’s coverage would cease if the employee and former spouse were still married to each other, but group health benefits will not be modified or ended during the first 120 days in a row after the employee’s death or end of the marriage unless the group health benefits under this plan are modified or ended for all employees or the class of employees to which the employee belongs; and (e) the end of two years from the date the person’s continued group health benefits began.
Dependent Spouse Continuation Rights (Cont.)

2. With respect to a retired employee’s spouse or the former spouse who has reached the age of 55 at the time continued group health benefits start: (a) the end of the period for which the last premium payment was made; (b) the date the person becomes covered for similar benefits under another group plan; (c) the date the former spouse remarries; (d) with respect to each covered person, the date such person’s coverage would cease, except due to the employee’s retirement, if the employee and former spouse were still married to each other, but group health benefits will not be modified or ended during the first 120 days in a row after the employee’s death or retirement or end of the marriage unless the group health benefits under this plan are modified or ended for all employees or the class of employees to which the employee belongs; and (e) the date the person reaches the qualifying age or otherwise becomes eligible for Medicare.

The Right To Convert

When a person’s continued group health benefits end, conversion rights to which he or she may be entitled will be available according to all the terms and conditions of this plan.

CGP-3-R-DSC-IL-04 B240.0253

Dependent Child Continuation Rights

Important Notice

This section applies to any hospital, surgical, medical, major medical, prescription drug, and dental expense coverages that are provided by this plan. In this section, these coverages are referred to as "group health benefits."

This section does not apply to coverages which provide benefits for loss of life or loss of income due to disability. These coverages, if provided, cannot be continued under this section.

Any continuation of group health benefits under this section will be subject to all of the terms and conditions of this plan.

If An Employee Dies While Covered

If an employee dies while covered, his or her then covered dependent child, or a responsible adult acting on behalf of the child, may continue this plan’s group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the child whose group health benefits would otherwise end. This continuation is not available if the child’s group health benefits are being continued as provided in the Dependent Spouse Continuation section.

If A Dependent Child Reaches This Plan’s Limiting Age

If an employee’s dependent child reaches this plan’s limiting age, he or she may continue this plan’s group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the child whose group health benefits would otherwise end.
How And When To Continue The Group Health Benefits

To continue the group health benefits, the employee’s dependent child must be covered for group health benefits under this plan at the time the employee dies or the child reaches this plan’s limiting age. The child, or a responsible adult acting on behalf of the child in the case of the employee’s death, must: (a) give written notice to Guardian or the employer of the death of the employee or the child reaching the limiting age within 30 days after such event occurs; and (b) elect to continue the group health benefits and pay the first monthly premium as described below.

If the child, or a responsible adult acting on behalf of the child in the case of the employee’s death, fails to elect to continue group health benefits, and/or fails to pay the first monthly premium, within 30 days after the date he or she receives the notice described below, group health benefits will end, and he or she waives the right to continue group health benefits under this plan.

The Employer’s Responsibility

The employer must give written notice to Guardian within 15 days of the date of receipt of written notice from the child, or a responsible adult acting on behalf of the child in the case of the employee’s death, of the death of the employee or the child reaching the limiting age. The employer’s notice must include the child’s place of residence. The employer must also send, at the same time, a copy of such notice to the child, or the responsible adult acting on behalf of the child in the case of the employee’s death, at the child’s place of residence.

Guardian’s Responsibility

Within 30 days after the date of receipt of written notice from the employer, child, or a responsible adult acting on behalf of the child in the case of the employee’s death of the death of the employee or the child reaching the limiting age, Guardian will notify the child, or the responsible adult acting on behalf of the child of his or her right to continue group health benefits for the child whose group health benefits would otherwise end.

Guardian's notice will be sent by certified mail, return receipt requested to the child’s place of residence. This notice will include: (a) a form for electing to continue group health benefits; (b) the amount of periodic premiums to be charged to continue group health benefits, and the method and place of payment; and (c) instructions for returning the election form within 30 days after the date it is received.

If Guardian fails to give notice as required above, all premiums for continued group health benefits will be waived from the date notice was required until the date notice is sent. Except as stated below, group health benefits will continue under the terms and conditions of this plan from the date notice was required until the date notice is sent. This will not apply where the group health benefits that exist at the time the notice was to be sent are ended for all employees or the class of employees to which the employee or deceased employee belongs.

Premiums

The monthly premium for continued group health benefits will be computed as follows: (a) an amount, if any, that would be charged an employee if the child were a current employee of the employer; plus (b) an amount, if any, that the employer would contribute toward the premium if the child were a current employee.
Continued group health benefits end for the covered child on the first to occur of the following:

(a) the end of the period for which the last premium payment was made;
(b) the date the child becomes covered for similar benefits under another group plan;
(c) the date the child’s coverage would cease if he or she was still an eligible dependent of the employee; and
(d) the end of two years from the date the child’s continued group health benefits began.

When a child’s continued group health benefits end, conversion rights to which he or she may be entitled will be available according to all the terms and conditions of this plan.
ELIGIBILITY FOR DENTAL COVERAGE

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.

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.

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

**Continuation During A Family Leave Of Absence**

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

- the *employer* must allow for a leave of absence under Federal Law, in which case;

- the section applies to you.

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

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

CGP-3-EC-90-3.0

**Dependent Coverage**

**Eligible Dependents For Dependent Dental Benefits**

Your *eligible dependents* are: your legal spouse; your unmarried dependent children who are under age 19; and your unmarried dependent children, from age 19 until their 23rd birthday, who are enrolled as full-time students at accredited schools.

CGP-3-DEP-90-2.0

**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 home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

CGP-3-DEP-90-3.0

**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-90-3.0

**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.

CGP-3-DEP-90-3.0
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.

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.

When Dependent Coverage Starts

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

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

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

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

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

CGP-3-DEP-90-6.0

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

Newborn Children

We cover your newborn child for dependent benefits, 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 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 once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

CGP-3-DEP-IL-93

When Dependent Coverage Ends

Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We’ll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.
If a surviving dependent elects to continue his or her dependent benefits under this plan’s "Federal Continuation Rights" provision, or under any other continuation provision of this plan, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

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

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

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

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

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

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

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

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

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

The domestic partner’s dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee’s dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

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

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

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

The Guardian Life Insurance Company of America

Vice President, Group Products

CGP-3-A-DMST-96 B210.0016
This page provides a quick guide to some of the Dental Expense Insurance plan features which people most often want to know about. But it’s not a complete description of your Dental Expense Insurance plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

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

- **Non-PPO Benefit Year Cash Deductible for Non-Orthodontic Services**
  
  For Group I, II and III Services ......................................... $50.00
  for each covered person

- **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%

- **Benefit Year Payment Limit for Non-Orthodontic Services**
  
  For Group I, II and III Services ................................. Up to $1,000.00

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

**Special Enrollment Period:** Once each year, during the group enrollment period from November 1st to December 15th, you may elect to enroll in one of the dental expense plan options offered by your employer, or to transfer to another dental expense plan option offered by your employer. Coverage under the new plan option starts on the January 1st that next follows election. Late entrant penalties do not apply to you and your eligible dependents if you enroll during this period.
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

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

Covered Charges

Whether a covered person uses the services of a preferred provider or a non-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.

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.

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.

Alternate Treatment

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

Proof Of Claim

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

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.

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.

The Benefit Provision - Qualifying For Benefits

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:
The Benefit Provision - Qualifying For Benefits (Cont.)

- 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

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

There is no deductible for Group I services provided by a preferred provider. We pay for such Group I covered charges at the applicable payment rate.

A benefit year deductible of $50.00 apply to Group II and III services provided by a preferred provider. A benefit year deductible of $50.00 applies to 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 I Non-PPO and all Group II and III covered charges above that amount at the applicable payment rate for the rest of that benefit year.

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,000.00.
The Benefit Provision - Qualifying For Benefits

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

CGP-3-DG-ROLL-04-2.1

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

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

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

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

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

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

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

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

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

- only claims incurred on or after January 1 will count toward the Rollover Threshold; and

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Rewards will not be applied to a covered person’s Bank until the benefit year that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a covered person for a period set forth in the provision of this plan called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the covered person until the next benefit year, and:

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

Definitions of terms used in this provision:

“Bank” means the amount of a covered person’s accrued Reward.

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

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

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

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%

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.
Special Limitations

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.

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.

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this plan's List of Covered Dental Services.

- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan.

- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.

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

- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
Exclusions (Cont.)

- Any restoration, procedure, or appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this plan.

- The use of local anesthetic.

- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment.

- Replacement of a lost, missing or stolen appliance or dental prosthesis; or the fabrication of a spare appliance or dental prosthesis.

- Prescription medication.

- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.

- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.

- Pulp vitality tests; or caries susceptibility tests.

- Bite registration; or bite analysis.

- Gingival curettage.

- The localized delivery of chemotherapeutic agents.

- Tooth transplants.

- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.

- Temporary or provisional dental prosthesis or appliances. But, this does not include interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan.

- Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant. This includes any incremental charges to other covered services as a result of the presence of a dental implant.
Exclusions (Cont.)

- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a dental prosthesis; and (2) odontoplasty.

- Replacing an existing appliance or dental prosthesis with any appliance or prosthesis, unless it is: (1) at least 5 years old and is no longer usable; or (2) damaged while in the covered person's mouth in an injury suffered while insured, and can not be made serviceable.

- A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.

- The replacement of extracted or missing third molars/wisdom teeth.

- Treatment of congenital or developmental malformations; or the replacement of congenitally missing teeth.

- Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

- Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).

- Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.

- Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.

- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.

- Orthodontic treatment.
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

Group I - Preventive Dental Services
(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to a total of one 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 14 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 one treatment 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 one 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.

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

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Group I - Preventive Dental Services (Cont.)
(Non-Orthodontic)

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.

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 36 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

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

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.

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

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

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

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.

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.

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 one prophylaxis or periodontal maintenance procedure 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.

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

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**Other Services**

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

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206
Group III - Major Dental Services
(Non-Orthodontic)

**Major Restorative Services**

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

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

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

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

- **Implant supported prosthetics** - Allowance includes the treatment plan and local anesthetic.
  - Abutment supported crown
  - Implant supported crown
  - Abutment supported retainer for fixed partial denture
  - Implant supported retainer for fixed partial denture
  - Implant/abutment supported fixed denture for completely edentulous arch

**Prostodontic Services**

Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.
Group III - Major Dental Services (Cont.)  
(Non-Orthodontic)

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

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

Bridge Pontics
Resin with metal
  Porcelain
  Porcelain with metal
  Full cast metal
  3/4 cast metal crowns
  3/4 porcelain crowns

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

Complete or Immediate dentures, upper or lower

Partial dentures - Allowance includes base, clasps, rests and teeth
  Upper, resin base, including any conventional clasps, rests and teeth
  Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth
  Lower, resin base, including any conventional clasps, rests and teeth
  Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth
  Interim partial denture (stayplate), upper or lower, covered on anterior teeth only
  Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit
### 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

### 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, maxilla or mandible
- 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
- Removal of upper or lower torus
- Oroantral fistula closure
- Sialolithotomy
- Sialodochoplasty
- Closure of salivary fistula
- Excision of salivary gland
- Maxillary sinusotomy for removal of tooth fragment or foreign body
- Vestibuloplasty

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered By This Plan

A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

(a) he or she receives services or supplies from a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) network; and

(b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.
Discounts on Dental Supplies Not Covered By This Plan

A covered person under this plan may receive discounts on certain supplies not covered by this plan, if he or she receives the supplies from either a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) network or a vendor that is under contract with Guardian.

The supplies described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist or the vendor. There is no need to file a claim.

When a person is no longer covered by this plan, access to any available discounts end.

Discounts on Services Not Covered Due To Contractual Provisions

If a covered person receives dental services from a dentist who is under contract with Guardian’s DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of our DentalGuard Preferred PPO network, even if such services are not covered by the plan due to:

- Meeting the plan’s benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions, such as dental implants.

Discounts on Orthodontic Services

If a covered person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian’s DentalGuard Preferred PPO network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

- Pre-orthodontic treatment visit
- Limited orthodontic treatment
- Interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- Comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits
- Periodic comprehensive orthodontic treatment visit (as part of a contract);
- Orthodontic retention, including fixed and removable initial appliances and related visits.
Discounted fees are not available for:

- Incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;
- Retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- Extractions performed solely to facilitate orthodontic treatment;
- Orthognathic surgery and associated incremental charges;
- Replacement of lost or broken retainers.

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ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

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 November 1st to December 15th 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.

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 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, the effective date shown on the sticker 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.

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.
Employee Vision Care Expense Coverage (Cont.)

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.

Continuation During A Family Leave Of Absence

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

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

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

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

Dependent Vision Care Expense Coverage

Your eligible dependents are: your legal spouse; your unmarried dependent children who are under age 19; and your unmarried dependent children, from age 19 until the day they reach age 23, who are enrolled as full-time students at accredited schools.

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 home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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.
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.

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

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

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

Once you have coverage for your initial dependents, you must notify us when you acquire any new dependents, and agree to make any additional payments required for the coverage. If you do this within 31 days of the date the newly acquired dependent becomes eligible, the dependent’s coverage will start on the date the dependent becomes eligible. If you fail to notify us on time, you can’t enroll the newly acquired dependent until the next vision open enrollment period.

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

Newborn Children
We cover your newborn child from the moment of birth if you’re already insured for dependent vision coverage, and you notify us within 31 days of the child’s birth. If you fail to notify us on time, you can’t enroll the child until the next vision open enrollment period.

If the newborn child is your first eligible dependent, we cover the child from the moment of birth if you enroll for dependent coverage and agree to make any required payments within 31 days of the child’s birth. If you fail to enroll on time, you can’t enroll the child until the next vision open enrollment period.

If the newborn child is not your first eligible dependent, but you did not previously enroll your other eligible dependents for vision care expense coverage, you can enroll the child during the next vision open enrollment period, if you also enroll all of your other eligible dependents at this time.

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 at 12:01 a.m. on the date 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 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 vision care benefits for a limited time.
CERTIFICATE AMENDMENT

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

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

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

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

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

The domestic partner’s dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee’s dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

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

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

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

The Guardian Life Insurance Company of America

Vice President, Group Products
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%
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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

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.
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.

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.

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
(800) 622-7444

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
Services or Supplies From a Preferred Provider (Cont.)

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 from the same 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

For Contact Lens Evaluation and Fitting Costs 15% off of the preferred provider’s usual and customary fee

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
Services or Supplies From a Non-Preferred Provider (Cont.)

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%

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 12 month period.

And if a covered person uses a non-preferred provider, we limit what we pay for each vision examination to $46.00.

CGP-3-VSN-96-LIST1 B505.0025
Covered Services and Supplies (Cont.)

**Standard Lenses**
We cover charges for single vision, bifocal, trifocal or lenticular lenses. We cover glass, plastic or for dependent children to age 19, polycarbonate lenses.

If a covered person uses a non-preferred provider, we limit what we pay to:
- $47.00 for each pair of single vision lenses
- $66.00 for each pair of bifocal lenses
- $85.00 for each pair of trifocal lenses and
- $125.00 for each pair of lenticular lenses.

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

**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 $120.00, 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 $47.

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.

**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.
Covered Services and Supplies (Cont.)

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.

**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 $120.00 once every 12 months.

**Special Limitations**

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.

**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.
- 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.

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.
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.

Group-Type Contracts
This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group.

Hospital Indemnity Benefits
This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

Plan
This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group or group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of $100.00 per day; (6) medical benefits under group automobile contracts, group or individual automobile “no-fault” contracts, and under traditional “fault” type contracts to the extent that such contracts are primary plans; and (7) Medicare or other governmental benefits, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of $100.00 or less per day; (ii) school accident type coverage; or (iii) 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.

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**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 following 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:
Coordination of Benefits (Cont.)

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

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

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

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

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.
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 any applicable benefit limit of this plan.

If the primary plan is an HMO and an HMO member has elected to have health care services provided by a non-HMO provider this plan will pay as if it is the primary 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.
WORKER'S COMPENSATION

For Persons Not Covered By Worker's Compensation

A covered person may not be eligible for, or may choose not to be covered by Worker’s Compensation. Such person may sustain an on-the-job or job-related injury. If this occurs, we provide benefits as described below:

(1) For all coverages under this plan, except those that provide benefits for loss of life or loss of income due to disability, we pay benefits for covered charges incurred by the covered person for care and treatment of such injury or condition to the same extent we’d pay benefits for covered charges due to any other sickness or injury.

But what we pay is based on all the terms of this plan.

(2) For any coverages that provide benefits for loss of income due to disability, we pay benefits for disability due to such injury or condition the same way we’d pay benefits for any other disability.

But what we pay is based on all the terms of this plan.

CGP-3-R-WCOMP-85

B595.0004
CERTIFICATE AMENDMENT

This plan is amended to include the following provision regarding our right of reimbursement.

If a covered person receives payment for damages as the result of sickness or injury that occurred due to the negligence, intentional act, or no-fault tort liability of a third party:

1. we have the right to reimbursement for any medical, dental or loss of earnings benefits we paid from any and all damages collected from the third party, or his or her insurer, for that same sickness or injury whether by action at law, settlement, or compromise, by the covered person, covered person’s parents, if the covered person is a minor, or covered person’s legal representative, if the covered person is a minor or incompetent, as a result of that sickness or injury; and

2. we are assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits we paid for that sickness or injury.

We shall have the right to first reimbursement out of all funds the covered person, the covered person’s parents, if the covered person is a minor, or the covered person’s legal representative, if the covered person is a minor or incompetent, is or was able to obtain as a result of the same sickness or injury for which we have paid benefits.

We are to be furnished any information or assistance, or be provided any documents that we may reasonably require, in order to obtain our rights under this provision. This provision applies whether or not the third party admits liability.

As used here:

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

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

The Guardian Life Insurance Company of America

Vice President, Group Products
This Glossary defines the italicized terms appearing in your booklet.

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

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

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

**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**.

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

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

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

**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.

**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.

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

**Covered Person**
means an employee or any of his or her covered dependents.
<table>
<thead>
<tr>
<th>Glossary Term</th>
<th>Definition</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered Person</td>
<td>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.</td>
<td>CGP-3-VSN-96-DEF3  B750.0462</td>
</tr>
<tr>
<td>Customary</td>
<td>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.</td>
<td>CGP-3-VSN-96-DEF3  B750.0484</td>
</tr>
<tr>
<td>Deductible</td>
<td>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.</td>
<td>CGP-3-VSN-96-DEF3  B750.0483</td>
</tr>
<tr>
<td>Dental Prosthesis</td>
<td>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.</td>
<td>CGP-3-GLOSS-90  B750.0670</td>
</tr>
<tr>
<td>Dentist</td>
<td>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.</td>
<td>CGP-3-GLOSS-90  B750.0671</td>
</tr>
<tr>
<td>Eligibility Date</td>
<td>for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.</td>
<td>CGP-3-GLOSS-90  B900.0003</td>
</tr>
<tr>
<td>Eligible Dependent</td>
<td>is defined in the provision entitled “Dependent Coverage.”</td>
<td>CGP-3-GLOSS-90  B750.0015</td>
</tr>
<tr>
<td>Emergency Treatment</td>
<td>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.</td>
<td>CGP-3-GLOSS-90  B750.0672</td>
</tr>
<tr>
<td>Employee</td>
<td>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.</td>
<td>CGP-3-GLOSS-90  B750.0006</td>
</tr>
<tr>
<td>Employer</td>
<td>means AURORA UNIVERSITY.</td>
<td>CGP-3-GLOSS-90  B900.0051</td>
</tr>
</tbody>
</table>
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.

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

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.

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.

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.

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.

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.

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

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

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.
### 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*.

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

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

### 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.

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

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

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

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

### 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.

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

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

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.

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

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

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

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

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.

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

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

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.

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.

The Guardian is located at 7 Hanover Square, New York, New York 10004.
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;
Group Health Benefits Claims Procedure (Cont.)

- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and

- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

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

- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and

- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person’s subordinate.

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

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

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

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

**Alternative Dispute Options**

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