



YOUR GROUP INSURANCE PLAN BENEFITS

RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA:

EXTENDED CARE HOSPITAL OF WESTMINSTER

CLASS 0003

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

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

The Guardian Life Insurance Company of America

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM

B999.0042

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

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

The Group Term Life Insurance described in this Certificate is attached to the group Policy effective December 1, 2021. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP TERM LIFE INSURANCE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) satisfy any necessary Proof of Insurability requirements; and (d) all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

FOR INSURED PERSONS AGE 65 OR OLDER WHO PAY SOME OR ALL OF THE COST OF THIS INSURANCE: YOU HAVE A 30 DAY EXAMINATION PERIOD AFTER THE RECEIPT OF THIS CERTIFICATE DURING WHICH YOU MAY CANCEL THE COVERAGE AND RETURN THIS CERTIFICATE BY MAIL OR OTHER DELIVERY METHOD. SUCH RETURN WILL VOID THE CERTIFICATE FROM THE BEGINNING, AND THE PARTIES WILL BE IN THE SAME POSITION AS IF A CERTIFICATE HAD NOT BEEN ISSUED. ALL PREMIUMS PAID WILL BE FULLY REFUNDED IN A TIMELY MANNER NOT LATER THAN 30 DAYS AFTER THE COMPANY RECEIVES THE RETURNED CERTIFICATE.

Policyholder: RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA: EXTENDED CARE HOSPITAL OF WESTMINSTER

Group Policy Number: 00531743

The Guardian Life Insurance Company of America

A handwritten signature in black ink, appearing to read 'H. Oliner', with a stylized, flowing script.

Harris Oliner, Senior Vice President,
Corporate Secretary

A handwritten signature in black ink, appearing to read 'M. Prestileo', with a stylized, flowing script.

Michael Prestileo,
Senior Vice President

B401.1935

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COMPLAINT NOTICE

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

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, NY 10001
(212) 598-8000

If You feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)
Website: www.insurance.ca.gov/01-consumers/

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GENERAL PROVISIONS

The Contract and Limitation Of Authority

The entire contract between the Policyholder and Us consists of:

- The Policy;
- The Schedule of Premium Rates;
- This Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; (5) and the application.

In the event of a conflict, the Policy shall reign.

We can amend the Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by the Policyholder and agreed to by Us; or
- On any date Our obligation under the Policy with respect to the Policyholder, or under this Certificate with respect to You, is changed because of statutory or other regulatory requirements.

Upon request, You may obtain a copy of the Policy from Us.

If We amend this Certificate, except upon request made by You, We must give You written notice of such change. Any amendments to this Certificate will be without prejudice to any claim arising prior to the date of the change.

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an enrollment form or other required form; and
- We have received any required premium.

If Proof of Insurability is required, You will not be covered unless You satisfy the Proof of Insurability requirements stated in the Certificate and Schedule of Benefits.

Incontestability

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

No statement in any application, made by You, or any dependent, will be used to contest the validity of Your insurance or to deny a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during Your lifetime.

If this Certificate replaces a plan Your Employer had with another insurer, We may rescind this Certificate based on misrepresentations or omissions made by Your Employer or You in a signed application for up to two years from the Effective Date of the Policy.

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

Physical Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under the Certificate as often as We feel is reasonably necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.1937

ELIGIBILITY FOR GROUP TERM LIFE COVERAGE - EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Group Term Life coverage if You are:

- In an eligible class of Employees;
- An active Full time Employee;
- Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us; and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Group Term Life coverage if You are:

- A temporary or seasonal Employee.

Enrollment Requirement If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

Proof Of Insurability Part or all of Your insurance amounts may be subject to proof that You are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You provide such proof to Us and We approve it in writing.

The Waiting Period If You are in an eligible class, You are eligible for Group Term Life insurance under this Certificate after You complete the service waiting period, if any, established by the Employer.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple life insurance coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.3124

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage starts. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.3129

All Options

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to Sickness or Injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

Any part of Your coverage which is subject to Proof Of Insurability will not start unless You send such proof to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on Your approved Eligibility Date.

B400.3131

All Options

Delayed Eligibility Date For Employee Voluntary Term Life Insurance

If due to sickness or injury, You are not Actively at Work and working the minimum required number of hours of an Employee in Your eligible class, on the date Your Voluntary Term Life coverage is scheduled to start, We will postpone coverage for an otherwise covered loss for any condition that prevents you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.3132

All Options

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
 - Disability;
 - Death;
 - Retirement;
 - Layoff;

- Leave of absence;
 - The end of employment; and
 - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
 - The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
 - The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
 - The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. And, You may have the right to replace certain group benefits with converted policies. The Employer will notify you of any conversion options available.

B400.3135

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance for the amount of basic and voluntary term life insurance for which You are insured on Your last day of Active Work, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and are receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date We request it. Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months.

If You become Disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.3138

All Options

**ELIGIBILITY FOR GROUP TERM LIFE COVERAGE
DEPENDENT COVERAGE**

B400.3143

All Options

**Eligible Dependents For Dependent Voluntary
Term Life Insurance**

Your eligible dependents are Your:

- Spouse who is under age 70; and
- dependent children from birth until they reach age 26.

B400.3190

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. However, to qualify as a dependent, each person must be chiefly dependent upon on You for support and maintenance. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

B401.1940

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.3201

All Options

**Continuing Coverage For Dependent Children
Past the Limiting Age**

If You have a child or children who:

- Is/are incapable of self-sustaining employment by reason of an intellectual disability or physical handicap; and

- Is/are chiefly dependent upon You for support and maintenance,

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied.

Each such child:

- Must have an intellectual disability or physical handicap that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group life policy that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- Remains:
 - Incapable of self-sustaining employment; and
 - Primarily dependent upon You for most of his or her support and maintenance; and

You must send Us written proof, and we must approve such proof, of the child's disability or handicap and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B401.1941

All Options

Proof Of Insurability

Part or all of Your dependent insurance amounts may be subject to proof that they are insurable. The Schedule of Benefits explains if and when We require Proof of Insurability. Your dependents will not be covered for any amount that requires Proof of Insurability until You provide that proof to Us and We approve that proof in writing.

B400.3203

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception shown below and to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

Initial Dependents If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.3204

All Options

Exception We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is confined to a hospital or other health care facility or home confined.

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date of his or her discharge from such facility or his or her home confinement ends.

If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B401.1943

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends; or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your class.

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary life coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70.

Read this Certificate carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And, they may have the right to replace certain group benefits with converted policies.

B400.3210

EMPLOYEE TERM LIFE INSURANCE

B400.3211

All Options

Basic Term Life Insurance

If You die while covered for Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This Life Insurance If You assign this insurance, You permanently transfer all Your rights under this insurance to the assignee.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

Unless otherwise specified by You, the assignment shall take effect on the date the notice of assignment is signed by You, subject to any payments made or actions taken by Us prior to receipt of the notice.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment. Assigning this life insurance may limit Your ability to exercise certain rider benefits.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We will reimburse up to \$5,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and AD&D contracts will not exceed \$5,000.

B401.2789

All Options

Voluntary Term Life Insurance

Subject to the limitations and exclusions shown below, if You die while covered for this Group Term Life insurance, We will pay Your beneficiary the amount shown in the Schedule Of Benefits for the plan of voluntary term life insurance You have elected. The voluntary term life insurance amount may be subject to reductions. These reductions are also shown in the Schedule Of Benefits. Your voluntary term life insurance amount, a part of it, or increases in such amount may not become effective until You submit Proof Of Insurability to Us, and We approve it in writing. These requirements are also shown in the Schedule Of Benefits.

B401.2790

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your death is due to suicide, and if such death occurs within 2 years from Your voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your death is due to suicide, and if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary Group Term Life insurance plan Your Employer had with another insurer, You will be given credit for the amount of time covered under the prior plan's Suicide Exclusion if:

- You were covered under the prior plan when it ended;
- You Enrolled for voluntary Group Term Life insurance under this Certificate on or before this Certificate's effective date; and
- You are Actively At Work on the effective date of this Certificate.

If You satisfy these conditions We will credit any time covered under the prior term life plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your voluntary term life insurance benefit under this Certificate if it is more than the benefit for which You were insured under the prior term life plan. In this case, We limit the benefit to the amount You would have been entitled to under the prior term life plan.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice; unless You have assigned this insurance. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;

- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Assigning This Life Insurance If You assign this insurance, You permanently transfer all Your rights under this insurance to the assignee. Only one of the following can be an assignee:

- Your Spouse;
- One of Your parents or grandparents;
- One of Your children or grandchildren;
- One of Your brothers or sisters; or
- The trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if:

- The assignment is in writing and signed by You; and
- A signed or certified copy of the written assignment has been received and approved by Us in writing.

We are not responsible for any legal, tax, or other effects of any assignment, or for any benefits We pay under this Certificate before We receive and approve any assignment. Assigning this life insurance may limit Your ability to exercise certain rider benefits.

We suggest You speak to Your lawyer before You make any assignment.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

Repatriation Benefit We will pay an extra sum for covered loss of life which occurs at least 75 miles from Your home. In that case, We reimburse up to \$5,000 to any person who incurred expenses to prepare and transport Your body to a mortuary chosen by You or an authorized agent. The total repatriation benefit payable under Your life and AD&D contracts will not exceed \$5,000.

B401.1945

CONVERTING THIS EMPLOYEE BASIC AND VOLUNTARY TERM LIFE INSURANCE

If Employment Or Eligibility Ends

Your group life insurance ends on the date:

- Your active Full-Time employment ends; or
- You stop being a member of an eligible class.

If Your group life insurance ends, Your Employer is responsible for providing You Notice of Your Right to Convert.

If You are not Totally Disabled, You can apply to convert Your Employee group basic and voluntary life insurance to a permanent life insurance policy.

You can apply to convert up to the full amount of basic and voluntary life insurance for which You were insured under this Certificate on the date Your insurance ended, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

If This Certificate Ends Or Group Life Insurance Is Discontinued

Your group life insurance also ends:

- If this Certificate ends; or
- Life insurance is discontinued from this Certificate for all Employees or for Your class.

If Your group life insurance ends for either of these reasons, You may apply to convert Your Employee group basic and voluntary life insurance to a Converted Policy.

You can apply to convert to a permanent life insurance policy, if

- You are not Totally Disabled; and
- You have been insured by a Guardian group life insurance plan or a group plan it replaces for at least five consecutive years.

However, the amount of life insurance that You can convert in either scenario is limited to the lesser of:

- \$2,000, or
- The amount of Your basic and voluntary life insurance under this Certificate, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

If You Are Totally Disabled

Your group life insurance ends on the date:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class;
- This Certificate ends; or

- Life insurance is discontinued from this Certificate for all Employees or for Your class;

and

- You are Totally Disabled; and
- You are eligible for Waiver of Premium Benefits pursuant to the Waiver of Premium Benefit Rider, but You have not yet been approved for the Waiver of Premium of Benefit,

You can apply to convert Your group term life insurance to:

- A permanent life insurance policy; or
- Interim term life insurance coverage.

You can apply to convert up to the full amount of basic and voluntary life insurance for which You are insured under this Certificate on the date Your insurance ends, less any group life insurance for which You become eligible in the 31 days after Your insurance under this Certificate ends.

However, if You have coverage under this Certificate's Exception to When Employee Coverage Starts, You may not convert if You are eligible or could become eligible under the prior plan's waiver of premium provision.

If You have converted and are later approved for this Certificate's Waiver of Premium Benefit, the Converted Policy will be cancelled as of the date You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit.

Interim Term Life Insurance

You may choose to apply to convert to interim term life insurance coverage if:

- You are Totally Disabled; and
- You may be eligible for Waiver of Premium Benefits based upon Your age, but You have not yet been approved for the Waiver of Premium Benefit.

If interim term life insurance coverage is issued to You, it can remain in force for up to one year from the date the interim term life insurance coverage goes into force and effect.

If You are approved for this Certificate's basic and voluntary Waiver of Premium Benefit during this year, the interim term life insurance coverage will be cancelled as of the date that You are approved for the Waiver of Premium Benefit. In this instance, Your coverage under this Certificate will continue subject to its terms, provided You remain eligible for the Waiver of Premium Benefit. If You have not been approved for this Certificate's basic and voluntary Waiver of Premium Benefit, the interim term life insurance coverage will end exactly one year from the first day said coverage goes into force and effect, and Your life insurance will be converted to a permanent life insurance policy. Premiums for the permanent life insurance policy will be based on Your age as of the date You convert from the interim term life insurance coverage.

If You are Totally Disabled, but You are not eligible for the Waiver of Premium Benefit based on Your age, You can apply to convert to a permanent life insurance policy.

How and When to Convert To obtain a Converted Policy, We must receive a written application fully completed by You, and all required premiums within the Conversion Period. Your Employer is responsible for providing You with Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. We will not ask for proof that You are insurable. In order to obtain a Converted Policy, You must satisfy all conditions required to convert within the Conversion Period.

Coverage will begin under the Converted Policy when We receive:

- A written application fully completed by You; and
- All required premiums during the Conversion Period.

Death During The Conversion Period We will pay a death benefit equal to the amount of life insurance that could have been converted if:

- You die within the Conversion Period; and
- But for Your death, You would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to the beneficiary You designate under the group Certificate. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.8584

All Options

Portability And Conversion If You choose to convert, this Certificate's portability privilege will not be available. In the event that a person would be eligible to both convert and to port, only one of these privileges may be chosen. Coverage under both a Conversion Policy and a portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

B400.3234

DEPENDENT TERM LIFE INSURANCE

B400.3235

Voluntary Term Life Insurance

A Subject to the limitations and exclusions shown below, If Your dependent dies while insured for this benefit, We will pay You the amount shown in the Schedule Of Benefits. If You are not living when Your dependent dies, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit to the Spouse's estate. If there is no established estate, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouse's children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your child's custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your child's estate;
- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your child's siblings.

We have the option of paying up to \$500 of this benefit to any person who incurred expenses for your dependent's funeral.

B401.2793

All Options

The Choices: You may elect coverage of any of the plans of dependent Spouse voluntary term life insurance and any of the plans of dependent child voluntary term life insurance offered by the Employer. These plans are shown in the Schedule Of Benefits. But, You can only be covered for one Spouse plan and one child plan at a time. You must notify the Employer of Your election and pay the required premium.

You may switch to another Spouse and child plan during the dependent voluntary life enrollment period shown in the Schedule Of Benefits. Subject to any of this Certificate's Proof Of Insurability requirements, You will be covered for the new plan as of the transfer date shown in the Schedule of Benefits. You must notify the Employer of any desired switch.

B400.3242

All Options

Suicide Exclusion We pay no voluntary term life insurance benefits if Your dependent's death is due to suicide, if such death occurs within 2 years from his or her voluntary term life insurance effective date under this Certificate. And, We pay no increased voluntary term life insurance benefit amount if Your dependent's death is due to suicide, if such death occurs within 2 years from the effective date of the increase.

If this Certificate replaces another voluntary term life insurance plan Your Employer had with another insurer, your dependent may be given credit for the amount of time covered. If your dependent was:

- Covered under the prior plan when it ended;
- Enrolled for insurance under this Certificate on or before this Certificate's effective date; and
- You were actively working on the effective date of this Certificate;

We credit any time covered under the prior plan toward meeting this Certificate's 2 year Suicide Exclusion requirement.

However, We limit Your dependent voluntary term life insurance benefit under this Certificate if it is more than the benefit for which Your dependents were insured under the prior plan. In this case, We limit the benefit to the amount Your dependents would have been entitled to under the prior plan.

B400.3246

CONVERTING THIS DEPENDENT TERM LIFE INSURANCE

**If A Dependent's
Life Insurance Ends**

Dependent term life insurance ends for all of Your dependents when Your group life insurance eligibility ends. Your group life insurance eligibility ends if:

- Your active Full-Time employment ends;
- You stop being a member of an eligible class; or
- Your group life insurance is continued under the Waiver of Premium Benefit provision; or
- You die.

Dependent term life insurance also ends when You stop being a member of a class of Employees eligible for dependent term life insurance.

If Dependent Life Insurance ends for any of the above reasons any dependent who was insured under this Certificate may apply to convert all or part of the amount for which he or she was insured on the day before insurance ended. Your Employer is responsible for notifying You or Your dependents of any conversion options available.

Your dependent may apply to convert up to the full amount of voluntary life insurance for which he or she was insured under this Certificate on the date his or her insurance ended to a permanent life insurance policy.

**If This Certificate
Ends Or Group Life
Insurance Is
Discontinued**

Dependent term life insurance also ends for all of Your dependents:

- If this Certificate ends; or
- Dependent life insurance is discontinued from this Certificate for all Employees or for Your class.

If Dependent term life insurance ends for either of these reasons, and any of Your dependents have been insured by a Guardian Group plan, or a group plan it replaces, for at least five consecutive years, each such dependent may apply to convert to a permanent life insurance policy.

However the amount that he or she can convert in either scenario is limited to the lesser of:

- \$2,000; or
- The amount of Your dependent's life insurance under this Certificate, less any group life insurance for which Your dependent becomes eligible in the 31 days after dependent life insurance under this Certificate ends.

**If A Dependent
Stops Being Eligible**

A dependent's term life insurance ends when he or she stops being an eligible dependent. A Spouse is no longer an eligible dependent when:

- A marriage is lawfully terminated; or

- He or she reaches age 70.

A child is no longer an eligible dependent when he or she reaches the limiting age.

If a dependent stops being eligible, he or she may convert all or part of the amount for which he or she was insured on the day before insurance ended to a permanent life insurance policy.

B401.1965

All Options

How And When to Convert To obtain a Converted Policy, We must receive a written application fully completed by You or Your dependent, and all required premiums within the Conversion Period. Your Employer is responsible for providing You and Your dependents with written Notice of Your Right to Convert within 15 days of the date Your group life insurance ends. You will have 31 days after Your dependent group voluntary life insurance ends to convert. We will not ask for proof that he or she is insurable. If the dependent is a minor or incompetent, the person who cares for and supports the dependent may apply for him or her.

Death During The Conversion Period We will pay a death benefit equal to the amount of dependent life insurance that could have been converted if:

- Your dependent dies within the Conversion Period; and
- But for his or her death, Your dependent would have been entitled to purchase a Converted Policy; and
- We receive Proof of Loss.

Any benefit payable under the group Certificate will be paid to you. However, if the Converted Policy has already taken effect, any benefit payable under the Converted Policy will be paid to the beneficiary You or Your dependent designated for the individual life insurance on the application for conversion. Under no circumstances will a benefit be paid under both the group Certificate and the Converted Policy.

B400.3501

CLAIM PROVISIONS

Your right to make a claim for Group Term Life insurance benefits provided by this Certificate is governed as follows:

Administration We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits under this Plan.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.
- Consider and interpret the terms of this Plan and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Plan and applicable California state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

All such determinations are conclusive and binding, except that they may be modified or reversed by a court or regulatory agency with appropriate jurisdiction.

Notice of Claim Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss You must send written Proof of Loss to Our designated office within 90 days of the loss.

Late Notice and Proof of Loss We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America
Group Life Claims Department

P.O. Box 981573
El Paso, TX 79998-1573

Payment Of Benefits Subject to all the terms of this Certificate, We will pay this insurance as soon as We receive written Proof of Loss. This should be sent to Us as soon as possible. We will pay this benefit in a lump sum.

Interest will be paid on the proceeds if not paid within 30 days of the death of the Insured. Interest will be computed daily at the rate of interest currently payable on individual life policy dividends left on deposit. Such amount shall be added to the life insurance benefit amount.

Legal Actions No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B401.2794

All Options

DEFINITIONS

This section defines certain terms appearing in this Certificate.

B400.3503

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, on a Full-Time basis at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.3504

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.3506

All Options

Conversion Period This term means the consecutive 31 day period beginning on the date Your Employee and dependent group basic and voluntary life insurance ends.

B400.3512

All Options

Converted Policy This term means a policy which provides individual life insurance, on an interim term or permanent basis, resulting from the option to convert provided in the Policy. The Converted Policy will not provide any:

- Benefits for accidental death;
- Waiver of Premium Benefits; or
- Other supplemental benefits.

The benefits provided by the Converted Policy may not be the same as the benefits provided by this Certificate.

The premium for the Converted Policy will be based on

- Your risk and rate class under this Certificate; and
- Your age on the date the Converted Policy goes into effect.

B400.3513

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.3514

All Options

Disabled This term means the Covered Person is:

- Not able to perform any work for wage or profit; and
- Receiving Regular and Appropriate Care for the cause of Disability.

B400.3516

All Options

Doctor Any medical practitioner We are required by law to recognize. He or she must:

- Be properly licensed or certified by the laws of the state where he or she practices; and
- Provide services that are within the lawful scope of his or her practice.

B400.3517

All Options

Domestic Partner This term means Your domestic partner who is registered with the California Secretary of State.

B401.1950

All Options

Effective Date This term means the date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.3518

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who has completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.

- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire or the first date after the end of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility Date will be the later of:

- The Employee's date of hire;
- The first date after any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.3519

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as employees if the Conditions of Eligibility requirements are met.

B400.3521

All Options

Employer This term means RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA: EXTENDED CARE HOSPITAL OF WESTMINSTER .

B400.3522

All Options

Enrollment Period This term means the 31 day period which starts on the date the Covered Person first becomes eligible for coverage.

B400.3523

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the 6 months prior to the last full day worked was at least 20 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B400.3525

All Options

Initial Dependents This term means those eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your Initial Dependents.

B400.3526

All Options

Newly Acquired Dependent This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B400.3538

All Options

Notice of Right to Convert This term means the written notice presented to You by the Employer, delivered to Your last known address.

B400.3539

All Options

Policy or Plan This term means the Group Term Life insurance coverage described in the Policy and this Certificate.

B400.3541

All Options

Proof Of Insurability This term means the completion of an evidence of insurability requirement as defined in the Schedule of Benefits.

B400.3542

All Options

Proof of Loss This term means the documents that We use to substantiate a claim. Examples of documents used for Proof of Loss include:

- An original certified finalized death certificate;

- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B401.1951

All Options

Reasonable Accommodation This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

B400.3545

All Options

Regular and Appropriate Care This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as recommended by a Doctor to effectively manage these conditions; and
- Are receiving appropriate treatment designed to achieve maximum medical improvement in these conditions.

Appropriate treatment is that treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals, and such treatment must be provided by a Doctor or Doctors whose specialty is appropriate for Your:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Regular and Appropriate Care does not require treatment for a disabling condition where no additional medical treatment will likely cure or improve that condition, and You have achieved maximum medical improvement.

B401.1952

All Options

Spouse This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include Your Domestic Partner.

B401.1953

All Options

Total Disability and Totally Disabled This term means that, due to sickness or injury, the Covered Person is:

- Not able during the first 24 months of claimed Total Disability to perform all the material duties of his or her occupation with Reasonable Accommodation, and after 24 months he or she is not able to perform any occupation for which he or she is reasonably fitted by education, training or experience.

B401.1954

All Options

We, Us and Our These terms mean The Guardian Life Insurance Company of America.

B400.3550

All Options

You or Your These terms mean the insured Employee.

B400.3551

All Options

GROUP TERM LIFE SCHEDULE OF BENEFITS

B400.4199

All Options

Employee Basic Term Life Insurance Schedule

B400.4200

All Options

Basic Term Life Insurance Amount	Insurance Amount	\$20,000.00
		B400.4213

All Options

Reduction of Basic Life Insurance Amount Based on Age	If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 70, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70 but before You reach age 75 If You are less than age 75 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 75, by 60% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 75 but before You reach age 80. If You are less than age 80 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A.M Standard Time for Your place of residence on the date You reach age 80, by 65% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 80. With respect to any of the reductions described above, the reduced insurance amount is in place of the amount which otherwise applies to Your classification.
	B400.4362

All Options

Proof of Insurability Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization, and
- Records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements Proof Of Insurability requirements apply to Basic Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or

- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

If Your Active Full-Time Work ends before You meet any Proof Of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B400.4376

All Options

Employee Voluntary Term Life Insurance Schedule

B400.4492

All Options

Initial Election You may choose to be insured under the plan of Voluntary Term Life Insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.4493

All Options

Changing Election You may switch to another plan of Voluntary Term Life Insurance during the Voluntary life enrollment period. Each year, the Voluntary life enrollment period starts on November 1st and ends on November 30th. You must notify the Employer of any desired switch. We may require Proof Of Insurability before You become insured under the new plan of benefits. See below For details. If We do not require Proof, You will become insured under the new plan of benefits as of the December 1st which coincides with or next follows the end of the Voluntary life enrollment period.

B400.4495

All Options

Voluntary Term Life Insurance Amount *Plan A*

You may elect amounts of voluntary term life insurance in increments of \$10,000.00, but the amount may not be less than \$10,000.00 and may not exceed \$500,000.00.

B400.4510

All Options

Annual Election After You first enroll for Employee Voluntary Term Life Insurance, You may choose to increase Your amount of Voluntary Term Life Insurance by an amount not to exceed an increase of \$50,000 as shown above. This option is available once annually during the Voluntary life enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Term Life Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.4698

All Options

Family Status Change You may request a change to your Voluntary Term Life Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Voluntary Term Life Insurance amount or the addition of Employee voluntary term life for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Voluntary Term Life Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Voluntary Term Life Insurance in writing within 31 days after the date of the Family Status Change as described below.

Proof Of Insurability is not required for the change to Voluntary Term Life Insurance due to Family Status Change as long as the change to Your Voluntary Term Life Insurance does not exceed the Proof of Insurability requirements as shown in the Schedule of Benefits. Refer to When Coverage Begins and When Dependent Coverage Begins in the Eligibility section of Your Certificate for information regarding when this coverage is effective.

B400.3558

All Options

Reduction of Voluntary Life Insurance Amount Based on Age

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 70, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70, but before You reach age 75.

If You are less than age 75 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 75, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 75, but before You reach age 80.

If You are less than age 80 when Your insurance under this Policy starts, Your insurance amount is reduced at 12:01 A. M. Standard Time for your place of residence on the date You reach age 80, by 65% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. The reduced amount is in place of the amount which otherwise applies to Your classification. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 80.

B400.4735

All Options

Proof Of Insurability Requirements

Depending on the coverage selected, or as otherwise required in this Certificate, You may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the coverage requires an applicant to submit Proof of Insurability, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicants:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to an Applicants driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any condition that must be satisfied for coverage to begin, including but not limited to the requirement that the applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and

Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof of Insurability requirements apply to Voluntary Term Life Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof of Insurability in writing before the insurance, or the specified amount of insurance becomes effective.

We require Proof of Insurability as follows:

B400.4903

All Options

Except as provided for annual election, We require Proof of Insurability before You switch from Your current increment of Voluntary Term Life Insurance to an increment which provides a greater amount of insurance.

B400.5270

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.4906

All Options

We require Proof of Insurability for amounts of Voluntary Term Life Insurance which exceed \$100,000.00.

B400.4912

All Options

We require Proof for amounts of Voluntary Term Life Insurance which exceed of \$50,000.00, if Your scheduled Voluntary term life effective date is after You reach age 65.

B400.4915

All Options

We require Proof for amounts of Voluntary Term Life Insurance which exceed of \$10,000.00, if Your scheduled Voluntary term life effective date is after You reach age 70.

B400.4915

All Options

Dependent Voluntary Term Life Insurance Schedule

B400.5473

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Term Life Insurance and the plan of dependent child Voluntary life insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.5476

All Options

Voluntary Plan A
Dependent Spouse
Term Life Insurance You may elect amounts of voluntary dependent spouse term life insurance in increments of \$5,000.00, but the amount may not be less than \$5,000.00 and may not exceed \$250,000.00.
Amount

B400.5550

All Options

Voluntary Plan A
Dependent Child
Insurance Amount **Child's Age At Death** **Insurance Amount**
From birth but less than 14 days \$500.00
At least 14 days but
less than 26 years \$2,000.00

B400.6711

All Options

Voluntary Plan B
Dependent Child
Insurance Amount **Child's Age At Death** **Insurance Amount**
From birth but less than 14 days \$500.00
At least 14 days but
less than 26 years \$5,000.00

B400.6711

All Options

Voluntary Dependent Child Insurance Amount	Plan C Child's Age At Death	Insurance Amount
	From birth but less than 14 days	\$500.00
	At least 14 days but less than 26 years	\$10,000.00
		B400.6711

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B400.6002

All Options

In no event may the insurance amount of a dependent child exceed 100% of Your insurance amount.

B400.9361

All Options

Reduction of Dependent Voluntary Life Insurance Amount Based on Age	An employee's dependent benefits are reduced in the same manner as his or her employee benefits. The dependent reductions are based on the employee's age.	B400.5474
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All Options

Proof Of Insurability Requirements Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and

- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.6014

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.6018

All Options

A dependent is not covered by any part of this Policy that requires such proof until You give Us this proof and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependents will not be covered by this Policy again until You give Us new proof that they are insurable and We approve that proof in writing.

B400.6019

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6048

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance in excess of \$25,000.00 with respect to a dependent Spouse.

B400.6051

All Options

We require Proof of Insurability for any amount of dependent Voluntary Term Life Insurance In excess of \$10,000.00 with respect to a dependent Spouse, if the dependent Spouse's scheduled dependent Voluntary term life effective date is after he or she reaches age 65.

B400.6050

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Term Life Insurance after the time allowed for enrolling as specified in this Policy.

B400.6060

All Options

Changes to Insurance

B400.6066

All Options

Changes In Insurance Amounts	If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage will not become effective prior to the date You return to Active Work on a Full-Time basis.
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B400.6069

All Options

Changes In Insurance Classification	If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:
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- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.6072

SUPPLEMENTAL RIDER - Accelerated Life Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Note: This benefit is not available for retirees.

Employee Accelerated Basic and Voluntary Life Benefit

IMPORTANT NOTICE: USE OF THIS BENEFIT MAY HAVE TAX IMPLICATIONS. IT MAY ALSO AFFECT GOVERNMENT BENEFITS OR CLAIMS OF CREDITORS. YOU SHOULD CONSULT YOUR TAX OR FINANCIAL ADVISOR BEFORE YOU APPLY FOR THIS BENEFIT.

THE AMOUNT OF YOUR GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT.

**Accelerated Life
Benefit**

You may be eligible for an Accelerated Life Benefit if you meet the following conditions:

- You have a Terminal Condition;
- You supply the required written proof of Your Terminal Condition (see "Notice of Claim");
- You apply for this benefit in writing while living and before You attain age 60. If You are unable to request this benefit yourself, Your legal representative may request it on Your behalf.

This benefit is a payment of part of Your Group Term Life Insurance made to You before death. You may use this benefit in any way You choose, subject to the restrictions stated below.

If You qualify for the Accelerated Life Benefit, We will subtract the Gross Amount paid to You as an Accelerated Life Benefit from the amount of Your Group Term Life Insurance under the Certificate. The remaining amount of Group Term Life Insurance is permanently reduced by the Gross Amount of this benefit.

You may only receive one Employee Accelerated Life Benefit during Your lifetime. This benefit does not have to be repaid, even if You:

- Live longer than 12 months from the date We receive Your request for this benefit; or
- Recover from the Terminal Condition.

However, the amount of this benefit will not be restored to Your remaining Group Term Life Insurance. And, You may not receive another Accelerated Life Benefit under any circumstances and even if You:

- Have a relapse; or

- You are subsequently diagnosed as having another Terminal Condition.

Benefit Amount For The Accelerated Life Benefit The amount of the Accelerated Life Benefit for which You may apply is based on the amount of group term life insurance for which You are insured on the day before You apply for the benefit subject to the following minimum and maximum amounts.

The minimum benefit amount is the lesser of: (1) \$10,000.00; or (2) 75% of Your amount of Group Term Life Insurance.

The maximum benefit amount is the lesser of: (1) \$250,000.00; or (2) 75% of Your amount of Group Term Life Insurance.

Discount The amount of the Accelerated Life Benefit which is available to You is discounted to the present value in 12 months from the date this benefit is paid. The discount is based on the maximum adjustable policy loan interest rate permitted in the state in which the group policy is delivered.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is available from Us on request.

Payment Of The Accelerated Life Benefit If We approve Your request for this benefit, We pay the amount You have elected, less the present value discount. We pay this benefit to You in one lump sum. This payment is subject to all of the other terms of the Certificate.

Notice of Claim You must send Us written proof from a Doctor who is operating within the scope of his or her license that You have a Terminal Condition. We must approve such proof in writing before this benefit is paid.

Physical Examinations We may have You examined by a Doctor of Our choice to determine whether the Terminal Condition exists. We will pay the cost of such exam.

If We approve Your request to receive this benefit, We will provide You with a statement along with Your benefit payment which shows:

- The amount of the Accelerated Life Benefit You requested;
- The amount of the present value discount;
- The amount of Your Accelerated Life Benefit check; and
- The remaining amount of Your Basic and Voluntary Life Insurance coverage.

Even if You have been approved for a waiver of premium benefit under this Certificate, You may still apply for an Accelerated Life Benefit. But, if You convert Your Group Term Life Insurance, the terms of the converted life policy will apply. Any amount to which You could otherwise convert is permanently reduced by the gross amount of Your Accelerated Life Benefit.

If You Have Assigned Your Group Term Life Insurance If You have already assigned Your Group Term Life Insurance, or any portion thereof, You cannot apply for an Accelerated Life Benefit.

If You Are Legally Incompetent If You are not legally competent, Your lawful guardian, conservator, legal representative, or any person or fiduciary with the lawful authority to act on Your behalf or handle Your affairs may apply for the Accelerated Life Benefit on Your behalf.

Your Remaining Group Term Life Insurance The remaining amount of Your Group Term Life Insurance after You receive an Accelerated Life Benefit payment is subject to any increases or reductions that would otherwise apply to Your insurance. Applicable reductions are applied to the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

If Your Life Benefit is scheduled to reduce within 12 months of the date You apply for the Accelerated Life Benefit, any applicable reduction will also be applied to Your Accelerated Benefit amount.

The premium cost of Your remaining insurance is based on the amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

The total amount of Group Term Life Insurance Your beneficiary would otherwise receive on Your death is reduced by the Gross Amount of the Accelerated Life Benefit.

If You die after applying, and were eligible, for the Accelerated Life Benefit, but before We send You the benefit, Your beneficiary will receive the full amount of Group Term Life Insurance for which You were insured on the day before the date You applied for the Accelerated Life Benefit.

Restrictions We will not pay an Accelerated Life Benefit if:

- Your coverage under the Certificate ends for any reason after You apply for the Accelerated Life Benefit, but before We pay such benefit;
- You are required by law to use the proceeds of the Group Term Life Insurance from the Certificate to meet the claims of creditors, whether or not You are in bankruptcy;
- You are required by court order to pay all or part of the proceeds of the Group Term Life Insurance from the Certificate to another person; or
- You are required by a government agency to use the payment to apply for, receive or maintain a governmental benefit or entitlement.

Definitions This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Doctor:** Any medical practitioner We are required by law to recognize. He or she must:
 - Be properly licensed or certified by the laws of the state where he or she practices; and
 - Provide services that are within the lawful scope of his or her practice.
- **Gross Amount:** This term means the amount of the Accelerated Life Benefit elected by You before subtraction of the discount.

- **Group Term Life Insurance:** This term means the amount of Employee Basic and Voluntary Group Term Life Insurance for which You are insured under the Certificate. The term does not include any:
 - Accidental death benefits; or
 - Scheduled increase in the amount of Employee Basic and Voluntary group term life insurance that is due within the 12 month period after the date You apply for the Accelerated Life Benefit.
- **Terminal Condition:** This term means a medical condition that is reasonably expected to result in death within 12 months from the date You apply for the Accelerated Life Benefit.

The Guardian Life Insurance Company of America

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

Michael Prestileo, Senior Vice President

B401.1989

SUPPLEMENTAL RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

**Employee Basic and Voluntary Term Life Insurance and
Dependent Voluntary Term Life Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Basic and Voluntary term life insurance and dependent Voluntary term life insurance.

Seatbelt And Airbag Benefits If You die as a direct result of an automobile accident while properly wearing a seatbelt, We will increase Your term life benefit amount by \$10,000. And, if You die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your term life benefit amount by an additional \$5,000, for a total increase of \$15,000.

Notice of Claim: You must send Us a request which includes written proof that You were properly wearing a seatbelt must be provided. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits. We must approve such proof in writing before this benefit is paid.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your term life benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic and Voluntary term life insurance and Basic and Voluntary Accidental Death and Dismemberment insurance may not exceed \$30,000.

Late Notice and Proof of Loss: We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Group Life Claims Department

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While You are legally intoxicated; or
- While You are voluntarily using a controlled substance, unless:
 - It was prescribed for You by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

Dependent Seatbelt and Airbag Benefit

Seatbelt And Airbag Benefits If Your dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, We will increase his or her Voluntary term life benefit amount by \$5,000. And, if Your dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase his or her Voluntary term life benefit amount by an additional \$2,500, for a total increase of \$7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile accident directly resulting in his or her death, We will increase Your dependent term life benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile accident directly resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Dependent Voluntary term life insurance and Dependent Voluntary Accidental Death and Dismemberment insurance may not exceed \$15,000.

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an accident occurring:

- While Your dependent is legally intoxicated; or

- While Your dependent is voluntarily using a controlled substance, unless:
 - It was prescribed for the dependent by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

The Guardian Life Insurance Company of America

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

Michael Prestileo, Senior Vice President

B401.2009

SUPPLEMENTAL RIDER - Waiver of Premium Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

**Employee Basic and Voluntary Term Life Insurance
Waiver Of Premium Benefit**

Important Notice This rider applies to Your Basic and Voluntary term life insurance. It does not apply to any of Your dependent life insurance under the Certificate. To continue dependent life insurance, You must convert Your dependent coverage. See "Converting This Dependent Term Life Insurance" for details.

If You Are Disabled If You are Totally Disabled, and meet the requirements in "How And When To Apply," We will extend Your Basic and Voluntary life insurance without payment of premiums from You or the Employer in an amount equal to the amount of Basic and Voluntary life insurance for which You are insured on Your last day of Active Work.

How And When To Apply To apply for this benefit, You must submit, while living, written medical proof of Your Total Disability satisfactory to Us within one year of the start of that disability. Any claim filed after one year from the start of Total Disability will be denied, unless We receive written proof that:

- You lacked the legal capacity to file the claim; or
- It was not reasonably possible for You to file the claim within the required period of time.

To be approved for this benefit, You must:

- Become Totally Disabled before You reach age 60 and while insured by the Certificate; and
- Remain Totally Disabled for at least 9 months in a row.

You should apply for this benefit immediately at the start of Your Total Disability.

Continued Proof For Waiver of Premium Benefit We may require written proof that You remain Totally Disabled and receive regular Doctor's care to maintain this benefit. This proof must be given to Us within 30 days of the date We request it.

We can also require that You take part in a medical assessment by a medical professional of Our choice as often as We feel is reasonably necessary during the first 2 years We have waived Your life insurance premiums pursuant to the Rider. After 2 years, We cannot have You examined more than once a year.

Until You Have Been Approved For This Benefit If Your life insurance under the Certificate ends after You have become Totally Disabled and applied for Waiver of Premium Benefits, but before We have approved You for this benefit, You may:

- Continue to pay your group premium payments, including any part which would have been paid by the Employer, until You are approved or declined for this benefit; or
- Apply to convert to an individual permanent or term life insurance policy.

Please read "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how to convert.

Converting Your life insurance does not stop You from claiming Your rights under this section. But, if You apply to convert and obtain a policy, and We later approve You for this benefit, We will cancel the converted policy on the date We approve You for this Benefit. See "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how We do this. Once You are approved for this benefit, Your insurance under the Certificate will be reinstated at no further cost to You or the Employer.

If You are declined for the Waiver of Premium benefit, You will have the option to apply to convert to an individual permanent or term life insurance policy. If You do not convert within 31 days of the date You are declined for the Waiver of Premium benefit, and You have not returned to Active Work, Your coverage will end.

If the Certificate terminates before You are approved

If this group Certificate terminates and You are Totally Disabled and eligible, but not yet approved, for this Waiver of Premium benefit, You must apply to convert to an individual permanent or term policy, and remain insured under such policy until You are approved by Us for the Waiver of Premium benefit.

When This Waiver Begins

Once approved by Us, Your Waiver of Premium benefit will be effective on the date following the day You have been Totally Disabled for 9 months in a row.

When This Waiver Ends

Your Waiver of Premium benefit will end on the earliest of:

- The date You are no longer Totally Disabled;
- The date We ask You to be examined by Our Doctor, and You refuse;
- The date You do not give Us the proof of Total Disability We require;
- the date you have been out of the United States and/or Canada or a country or region approved by Us for more than 2 months in a 12 month period;
- The date You are no longer receiving regular Doctor's care appropriate to the cause of Your claimed Total Disability;
- The day before the date You reach age 65.

If Your Waiver of Premium Benefit ends and You do not return to Active Work, You will have the option to convert the Employee Basic and Voluntary life insurance that was in effect on the date the Waiver of Premium Benefit ends.

Please read "Converting This Employee Basic and Voluntary Term Life Insurance" for details on how to convert.

**If You Die While
Covered By This
Waiver of Premium
Benefit**

If You die while covered for this benefit, We will pay Your beneficiary the amount of Basic and Voluntary life insurance for which You were insured as of Your last day of Active Full-Time Work. This payment is subject to all the terms of the Certificate and all reductions which would have applied had You remained an Active at Work Employee.

**If You Die Prior to
Approval for This
Waiver of Premium
Benefit**

If You die prior to being approved for the Waiver of Premium Benefit and within 12 months of the onset date of Total Disability We'll pay Your beneficiary the amount for which You were covered as of Your last day of Active Full-Time Work, subject to all reductions which would have applied had You stayed an active Employee provided You:

- Were Totally Disabled, as defined by this Rider, through the date of death,
- Became Totally Disabled prior to age 60; and
- Became Totally Disabled while insured; and
- We received the required premiums for this coverage.

Proof Of Death

We will pay the term life insurance benefit as soon as We receive:

- Written proof of Your death; and
- Medical proof that You were continuously Totally Disabled until Your death.

This proof must be sent to Us within one year of Your date of death.

B400.7286

All Options

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

Reasonable Accommodation: This term means any modification or adjustment that the Employer willingly provides to:

- A job;
- An employment practice;
- A work process; or
- The work place.

The modification or adjustment must make it possible for a Disabled person to:

- Reach the same level of performance as a similarly situated non-disabled person; or
- Enjoy equal benefits and privileges of employment as are available to a similarly situated non-disabled person.

The modification or adjustment must not place an undue hardship on the Employer.

Regular and Appropriate Care: This term means, with respect to Your disabling condition(s) and any other condition(s) which, if left untreated, would adversely affect Your disabling condition, You:

- Visit a Doctor as frequently as recommended by a Doctor to effectively manage these conditions; and
- Are receiving appropriate treatment designed to achieve maximum medical improvement in these conditions.

Appropriate treatment is that treatment a patient would make a reasonable decision to accept after duly considering the options of medical professionals, and such treatment must be provided by a Doctor or Doctors whose specialty is appropriate for You:

- Disability; and
- Any other conditions which left untreated would adversely affect Your disabling condition.

Regular and Appropriate Care does not require treatment for a disabling condition where no additional medical treatment will likely cure or improve that condition and You have achieved maximum medical improvement.

"Total Disability" and "Totally Disabled": This term means that, due to sickness or injury, You are:

- Not able during the first 24 months of Your claimed Total Disability to perform all the major duties of Your occupation with Reasonable Accommodation, and after 24 months You are not able to perform any occupation for which You are reasonably fitted by education, training or experience.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B401.2001

SUPPLEMENTAL RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

PORTABILITY PRIVILEGE

This rider applies only to Your Employee Basic term life insurance.

**Portability
Conditions**

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
 - You are no longer employed by the Employer; or
 - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Basic term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
 - Failure to pay any required premium; or
 - Termination of the Certificate
- In order to Port, You must provide Proof Of Insurability.

Portability Options

You may Port the full amount of Your Basic term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least \$50,000 and does not exceed \$1,000,000.

**The Portable
Certificate Of
Coverage**

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port You must:

- Apply to Us in writing; and
- Pay the required premium.

You must do this within 31 days from the date Your coverage under the Certificate ends. In order to Port Your Basic term life insurance, We require Proof of Insurability.

Portability And Conversion If You choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port":** these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B400.3877

SUPPLEMENTAL RIDER - Portability Privilege

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

PORTABILITY PRIVILEGE

This rider applies only to Your Employee and dependent Voluntary term life insurance.

**Portability
Conditions**

Portability is subject to all of the conditions described below.

- You may Port if Your coverage under the Certificate if coverage ends because:
 - You are no longer employed by the Employer; or
 - You are no longer a member of an eligible class of Employees
- You may **not** Port unless You have been covered by the Certificate, or the plan it replaced, for Employee Voluntary term life insurance for at least three months in a row prior to the date Your coverage under the Certificate ends.
- You may **not** Port if You have reached age 70 on the date coverage under the Certificate ends.
- You may **not** Port if You are eligible for the Certificate's Waiver of Premium Benefit.
- You may **not** Port if coverage under the Certificate ends due to:
 - Failure to pay any required premium; or
 - Termination of the Certificate

Portability Options

You may Port the full amount of Your Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount, if such amount under the Certificate is at least \$50,000 and does not exceed \$1,000,000.

You may Port the full amount of Your dependent's Voluntary term life insurance in force as of the date Your coverage under the Certificate ends. If You do not wish to Port the full amount, You may choose to Port 50% of such amount if:

- Your dependent Spouse amount under the Certificate is at least \$10,000; and
- Your dependent child amount under the Certificate is at least \$2,000.

You may Port:

- Your insurance only;
- Your insurance and insurance of Your covered Spouse; or
- Your insurance and the insurance of all of Your covered dependents.

If You Port the full amount of Your insurance and You choose to Port Your dependent's insurance, You must Port the full amount of Your dependent's insurance. If You Port 50% of Your insurance and You choose to Port Your dependent's insurance, You must Port 50% of Your dependent's insurance.

A dependent must be insured as of the date Your coverage under the Certificate ends in order to be eligible for Portability.

If You die while insured for dependent Voluntary term life insurance, Your Spouse may Port Your dependent Voluntary term life insurance as described above. Your Spouse and dependent children must be insured under the Certificate on the date of Your death. But, this option is not available if:

- There is no surviving Spouse; or
- Your surviving Spouse has reached age 70 on the date of Your death.

The Portable Certificate Of Coverage

If You Port, You will obtain a new Certificate of coverage, which will be issued under the Portable group policy and will describe the benefits provided. The Portable group policy has been established specifically for, and limited to, providing portability coverage for Employees and their dependents whose coverage ends under an Employer's plan. The benefits provided by the Portable certificate of coverage may not be the same as the benefits provided by the Certificate provided by your Employer. The group term life insurance provided by the Portable Certificate of coverage will not provide any of the following benefits or types of coverage:

- Accidental death or dismemberment;
- Income replacement;
- Or Waiver of Premium benefits.

The premium for the Portable certificate of coverage will be based on:

- the covered person's rate class under the Ported Policy; and
- Your or Your surviving Spouse's age bracket as shown in the Life Portability Coverage Premium Notice.

The Portable Certificate of Coverage ends at age 70.

How To Port You or Your surviving Spouse must:

- Apply to Us in writing; and
- Pay the required premium.

You or Your surviving Spouse must do this within 31 days from the date Your coverage under the Certificate ends. In order to port Your Voluntary term life insurance, We will not ask for proof that You or Your surviving Spouse is insurable.

Portability And Conversion If You or Your surviving Spouse choose to Port, the Certificate's conversion privilege will not be available. In the event that a person would be eligible to both convert and to Port, only one of these privileges may be chosen. Coverage under both a converted policy and a Portable certificate of coverage at the same time is not permitted. You or Your surviving Spouse should read the entire Certificate, as well as any related materials carefully before making a choice.

Definitions

This section defines certain terms appearing in this Rider. Additional terms, not listed here, are defined in the Certificate.

- **Port or "To Port":**these terms mean to choose a Portable certificate of coverage which provides group term life insurance.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B400.3884

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0243

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Life Insurance Claims Procedure

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

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

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

Definitions

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

Timing for Initial Benefit Determination of Life Insurance Claims

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

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

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

**Adverse Benefit
Determination of
Life Insurance
Claims**

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

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

B997.0239

All Options

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

B997.0240

All Options

Appeals of Adverse Determinations for Waiver of Premium

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

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

**Alternative Dispute
Options**

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

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

B997.0241

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

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

The Group Accidental Death and Dismemberment Coverage described in this Certificate is attached to the group Policy effective December 1, 2021. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) satisfy any necessary Proof of Insurability requirements; and all required premium payments have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

FOR INSURED PERSONS AGE 65 OR OLDER WHO PAY SOME OF ALL OF THE COST OF THIS INSURANCE: YOU HAVE A 30 DAY EXAMINATION PERIOD AFTER THE RECEIPT OF THIS CERTIFICATE DURING WHICH YOU MAY CANCEL THE COVERAGE AND RETURN THIS CERTIFICATE BY MAIL OR OTHER DELIVERY METHOD. SUCH RETURN WILL VOID THE CERTIFICATE FROM THE BEGINNING, AND THE PARTIES WILL BE IN THE SAME POSITION AS IF A CERTIFICATE HAD NOT BEEN ISSUED. ALL PREMIUMS PAID WILL BE FULLY REFUNDED IN A TIMELY MANNER NOT LATER THAN 30 DAYS AFTER THE COMPANY RECEIVES THE RETURNED CERTIFICATE.

Policyholder: RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA: EXTENDED CARE HOSPITAL OF WESTMINSTER
Group Policy Number: 00531743

The Guardian Life Insurance Company of America



Harris Oliner, Senior Vice President,
Corporate Secretary



Michael Prestileo,
Senior Vice President

B401.2172

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COMPLAINT NOTICE

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

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, NY 10001
(212) 598-8000

If You feel Your complaints have not been resolved after contacting the Guardian You may contact the California Department of Insurance at the following address and phone number:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)
Website: www.insurance.ca.gov/01-consumers/

B401.2173

GENERAL PROVISIONS

The Contract and Limitation Of Authority

The entire contract between the Policyholder and Us consists of:

- The Policy;
- The Schedule of Premium Rates;
- This Certificate(s) which describe(s) the insurance for which Covered Persons are insured;
- Any attached riders, schedule of benefits or amendments; and Your application.

In the event of a conflict, the Policy shall reign.

We can amend the Policy at any time, without the consent of the insured Employees or any other person having a beneficial interest in it:

- Upon written request made by the Policyholder and agreed to by Us; or
- On any date Our obligation under the Policy with respect to the Policyholder, or under this Certificate with respect to You, is changed do to the requirements of state or federal law or regulation.

Upon request, You may obtain a copy of the Policy from Us.

If We amend this Certificate, except upon request made by You, We must give You written notice of such change.

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

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to:

- Determine whether any contract, policy or certificate is to be issued;
- Waive or alter any provisions of any contract or policy, or any of Our requirements;
- Bind Us by any statement or promise relating to the contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an enrollment form or other required form; and
- We have received any required premium.

Incontestability

Any statement made by You, in the absence of fraud, will be deemed a representation and not a warranty. No statement will be used to avoid insurance, reduce benefits or defend a claim unless it is material to the risk accepted or the hazard assumed by Us, has been signed by You, and a copy of the statement has been given to You or to Your Beneficiary. We shall not contest this coverage after it has been in force during Your lifetime for three years from the Effective Date of the Policy.

Physical Examination And Autopsy

We have the right to have a doctor of Our choice examine the person for whom a claim is being made under the Certificate as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

Overpayment Recovery

If We overpay benefits, all such benefits must be repaid in full. We have the right to reduce the benefit, or reduce any other benefits payable under this Certificate, toward recovery of any overpayment.

B401.2174

ELIGIBILITY FOR ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE EMPLOYEE COVERAGE

Conditions Of Eligibility

Subject to the conditions of eligibility set forth below, and to all of the other conditions of this Certificate, You are eligible for Accidental Death and Dismemberment coverage if You are

- In an eligible class of Employees;
 - Are an active Full time Employee;
 - Legally working in the United States and/or Canada or working outside of the United States for a United States based Employer in a country or region approved by Us;
- and
- Working at least the minimum number of hours of an Employee in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of your occupational duties.

You are **not** eligible for Accidental Death and Dismemberment coverage if You are

- A temporary or seasonal Employee.

The Waiting Period If You are in an eligible class, You are eligible for Accidental Death and Dismemberment coverage under this Certificate after You complete the service waiting period, if any, established by the Employer and as stated in the Schedule of Benefits.

Multiple Employment If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Accidental Death and Dismemberment Coverage under this Certificate. But, if this Certificate uses the amount of Your Insured Earnings to set the rates, determine class, figure insurance amounts, or for any other reason, such Insured Earnings will be figured as the sum of Your Insured Earnings from all covered Employers.

B400.6098

All Options

When Coverage Starts

For coverage to start, You must be fully capable of performing the major duties of Your regular occupation for the Employer and working the minimum required number of hours of an Employee in Your eligible class at 12:01 A.M. Standard Time for Your place of residence on Your scheduled Eligibility Date. And, for coverage to start, You must satisfy all of the Conditions of Eligibility described above, and the conditions shown below which apply to You. If You are not fully capable of performing the major duties of Your regular occupation on Your scheduled Eligibility Date, We will postpone the start of Your coverage until You are so capable and working the minimum required number of hours of an Employee in Your eligible class for one full day, with the capacity to do so for one full week.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not start until You send Us Proof Of Insurability. Once We approve such Proof Of Insurability, Your coverage will start on the date we approve such coverage.

B400.6103

All Options

Exception to When Coverage Starts Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury, of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

and if:

- You are fully capable of performing the major duties of Your regular occupation for Your Employer for the minimum number of hours of an Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date ; and
- You were performing the major duties of Your regular occupation and working the minimum number of hours of an Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, in no event will any coverage or part of coverage for which You must elect and pay all or part of the cost, start if You are on an approved leave, layoff or absence and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.6106

All Options

Delayed Eligibility Date For Employee Voluntary Accidental Death and Dismemberment Insurance

If due to sickness or injury, You are not Actively At Work and working the minimum number of hours of an Employee in Your eligible class on the date Your Voluntary Accidental Death and Dismemberment coverage is scheduled to start, We will postpone coverage for an otherwise Covered Loss for any condition(s) that prevent you from meeting the Actively at Work requirement. We will postpone such coverage until You:

- Complete one full day of Active Work, working the minimum number of hours of an Employee in Your eligible class, with the capacity to do so for one full week; and,
- Do not miss a day of work due to the same condition.

Coverage for an otherwise Covered Loss due to all other conditions will start on the date You:

- Return to Active Work working the minimum number of hours of an Employee in Your eligible class and;
- Are performing the regular duties of your occupation.

B400.6107

All Options

When Coverage Ends

Your coverage will end on the first of the following dates:

- The date Your Active Work ends for any reason, except as noted below under Coverage During Leave of Absence. Such reasons include:
 - Disability;
 - Death;
 - Retirement;

- Layoff;
 - Leave of absence;
 - The end of employment; and
 - Expiration of the employment contract.
- The date You stop being an eligible Employee under this Certificate.
 - The date You are no longer working in the United States and/or Canada, or no longer working outside the United States for a United States based Employer in a country or region approved by Us. Any incidental business or personal travel outside of the United States and/or Canada, or outside of a country or region approved by Us, is covered. Such travel will be considered incidental if it is for a period not to exceed 30 consecutive days.
 - The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
 - The last day of the period for which required payments are made for You.

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Contact Your Employer regarding any continuation options available.

B400.6110

CONTINUATION OF COVERAGE

Coverage During Disability

If Your Active Work ends because You are Totally Disabled, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The date you are no longer Totally Disabled, as defined by this Certificate;
- 12 months; from the date Your Total Disability began;
- The date you are approved for any Waiver of Premium Benefit for which you are eligible; or
- The date of Your 99th birthday.

We may require written Proof of Loss that You remain Totally Disabled and receiving regular Doctor's care to maintain this benefit. This Proof of Loss must be given to Us within 30 days of the date we request it.

Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Layoff

If Your Active Work ends because You are temporarily laid off, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premium, until the earlier of:

- The end of the temporary layoff; or
- The end of the month in which You are laid off plus 1 months following the date the temporary layoff begins.
- The end of the time period covered under a severance agreement not to exceed 1 months.

If You die or become Disabled under this Certificate while Your coverage is being continued during a temporary layoff, Your eligibility for benefits will be governed by all the terms of this Certificate.

Coverage During Temporary Leave of Absence

If Your Active Work ends because You go on a leave of absence that has been approved by Your Employer, You and Your Employer may agree to continue Your insurance, subject to continued payment of all required premiums, until the earlier of:

- The end of the Employer approved leave of absence; or

- The end of the month in which Your leave begins plus 1 months following the date the approved leave of absence begins.

If You become disabled under this Certificate while Your coverage is being continued during a leave of absence, Your eligibility for benefits will be governed by all the terms of this Certificate.

B400.6111

All Options

DEPENDENT COVERAGE

B400.6116

All Options

**Eligible Dependents For Dependent Voluntary Accidental
Death and Dismemberment Insurance**

Your eligible dependents are Your:

- Spouse who is under age 70; and
- Your dependent children who are under age 26.

B400.6120

All Options

Adopted Children And Step-Children

Your dependent children include Your legally adopted children and Your step-children. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

B401.2177

All Options

Dependents Not Eligible

We exclude:

- A dependent who is on Active Duty in any armed force.

B400.6128

All Options

**Continuing
Coverage For
Dependent Children
Past the Limiting
Age**

If You have a child or children who:

- Is/are incapable of independent living by reason of an intellectual disability or physical handicap; and
- Is/are primarily dependent upon You for support and maintenance;

Then, the child or children may remain eligible for dependent benefits past the age limit provided all the conditions shown below are satisfied.

Each such child:

- Must have an intellectual disability or physical handicap that began before he or she reached the dependent age limit;
- Became covered by this Certificate, or the prior carrier's group accidental death and dismemberment plan that it replaced, before he or she reached the dependent age limit, and remained continuously covered until he or she reached the age limit;
- and remains:
 - Incapable of independent living; and
 - Dependent upon You for most of his or her support and maintenance; and

You send Us written proof, and we approve such proof, of the child's disability or handicap and dependence within 31 days from the date he or she reaches the dependent age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year.

Irrespective of this provision, any coverage provided under this section ends when Your coverage ends.

B401.2178

All Options

When Dependent Coverage Starts

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception shown below and to all of the other terms of this Certificate, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments.

Initial Dependents If You enroll Your Initial Dependents on or before Your Eligibility Date, the dependents' coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You enroll Your Initial Dependents within the Enrollment Period, their coverage begins on the later of Your Eligibility Date and the date You become covered for Employee coverage.

If You do not enroll Your Initial Dependents when they are first eligible, and enroll those Initial Dependents after the Enrollment Period ends, You must supply Proof Of Insurability and coverage will not start until We approve that proof in writing.

If an Initial Dependent becomes eligible after this Certificate's Effective Date, his or her coverage will start on the date We approve him or her for coverage.

If Dependent Proof of Insurability is required Subject to the Exception shown below, if Proof Of Insurability is required for dependent benefits, You must send Us the proof We require, and We must approve that proof in writing. Those benefits will then begin on the approved Eligibility Date.

If You must pay part of the cost of dependent coverage, We will not cover You for such coverage until You enroll each of Your dependents, agree to make the required payments, submit Proof Of Insurability and We approve that proof in writing.

Newly Acquired Dependents If You do not pay any part of the cost of dependent coverage, a Newly Acquired Dependent is covered from the date he or she first becomes eligible.

If You must pay part of the cost of dependent coverage, and are already enrolled for dependent child coverage for Your Initial Dependent children, any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

However, if You were previously eligible to enroll for dependent child coverage and waived coverage or failed to enroll, We will not cover any of Your dependent children until You submit Proof of Insurability and we approve that proof in writing and you make any additional required payments.

B400.6130

All Options

Exception We will postpone the Eligibility Date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is confined to a hospital or other health care facility or home confined.

In that case, We will postpone the Eligibility Date of his or her coverage until the day after the date of his or her discharge from such facility or his or her home confinement ends.

If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan.

B401.2180

All Options

When Dependent Coverage Ends

Dependent coverage ends for all of Your dependents when:

- Your Employee coverage ends;
- You stop being a member of a class of Employees eligible for such coverage;
- This Certificate ends, or
- Dependent coverage is discontinued from this Certificate for all Employees or for Your class.

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

An individual dependent's coverage ends when he or she stops being an eligible dependent. For dependent children the coverage ends at 12:01 A.M. Standard Time for Your place of residence on the date the child attains this Certificate's age limit, or when a step-child is no longer dependent on You for at least 50% of their support and maintenance, or for Your disabled child who has reached the age limit, when he or she is no longer eligible under the Continuing Coverage for Dependent Children Past the Limiting Age provision.

Coverage ends for a Spouse when a marriage is lawfully terminated, and with respect to Voluntary Accidental Death and Dismemberment coverage, it happens at 12:01 A.M. on the date the Spouse reaches age 70 .

Read this Certificate carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time. And, they may have the right to replace certain group benefits with converted policies.

B400.6132

**EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT
(AD&D) INSURANCE**

B400.6134

**Basic and Voluntary Accidental Death and Dismemberment
Insurance And Catastrophic Loss Benefits**

B400.6138

We will pay the benefits described below if You suffer an irreversible loss due to an Accident and the Accident occurs while You are insured by this Certificate. The loss also must:

- Be a result of the Accident; and
- Occur within 365 days of the date of the Accident.

Payment Of Benefits We will pay this insurance as soon as We receive written Proof of Loss as shown in the Claims Provisions section of this Certificate.

Payment Of Benefits For Covered Loss of life, We pay the beneficiary of Your Accidental Death and Dismemberment Insurance under the Employer's Policy with Us.

For all other Covered Losses, We pay You if You are living. If You are not living, We pay the beneficiary of Your Term Life coverage under the Employer's Plan with Us.

Subject to all the terms of this Certificate, We pay all benefits in a lump sum as soon as We receive written proof of Covered Loss and proof of claim. This should be sent to Us as soon as possible.

The Beneficiary You decide who receives this benefit when You die. You may designate a beneficiary by doing so in writing on a form and filing the form with the Employer.

You can change Your beneficiary at any time by providing written notice. But, the change will not take effect until We or the Employer records the change.

We will not be liable for any amounts paid before receiving notice of a beneficiary change.

In no event may a beneficiary be changed by a Power of Attorney.

If You named more than one person as a primary beneficiary, but You do not specify what shares each such primary beneficiary is entitled to receive, We will divide the benefits equally among all such named primary beneficiaries who survive You. If someone You named as a primary beneficiary dies before You, that person's share will be divided equally by the primary beneficiaries still alive; unless You have specified otherwise.

If You have named a contingent beneficiary or contingent beneficiaries, We will pay Your contingent beneficiary or contingent beneficiaries, if no primary beneficiary survives You. If there is more than one contingent beneficiary who is eligible for benefits, We will divide the benefits equally among all such named contingent beneficiaries who survive You; unless You have specified otherwise.

If there is no primary or contingent beneficiary or beneficiaries eligible for benefits when You die, We will pay this benefit as follows:

- To Your Spouse;
- If Your Spouse does not survive You, then to Your children who survive You in equal shares;
- If no Spouse or children survive You, then to Your parents who survive You in equal shares;
- If no Spouse, children, or parents survive You, then to then to Your brothers and sisters in equal shares;
- If none of the above parties survive You, then to Your executors or administrators of Your estate.

Payment Of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for Your funeral.

B401.2183

All Options

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

B400.6147

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of Your AD&D insurance amount.
Disappearance	100% of Your AD&D insurance amount.
Loss of a hand	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".

Loss of a foot	50% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of Your AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of four fingers of same hand	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

CATASTROPHIC LOSS BENEFITS

Loss of speech and hearing	100% of Your AD&D insurance amount.
Loss of speech or hearing	50% of Your AD&D insurance amount.
Quadriplegia	100% of Your AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Paraplegia	75% of Your AD&D insurance amount.
Hemiplegia	50% of Your AD&D insurance amount.

Uniplegia	25% of Your AD&D insurance amount
Loss of cognitive function	100% of Your AD&D insurance amount.
Comatose state, in excess of one month	100% of Your AD&D insurance amount.
Loss of one arm or leg	75% of Your AD&D insurance amount.
Third degree burns covering 75% or more of the body	75% of Your AD&D insurance amount
Third degree burns covering 50% or more but less than 75% of the body	50% of Your AD&D insurance amount

B400.6144

All Options

As used here:

- "Loss of cognitive function" means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- "Loss of hearing" means that hearing in both ears is lost entirely.
- "Loss of sight" means total and permanent loss of sight.
- "Loss of thumb and index finger of same hand" or "Loss of four fingers of same hand" means complete severance at the metacarpophalangeal joints of the same hand.
- "Loss of all toes of same foot" means complete severance at the metatarsalphalangeal joint.
- "Loss of the great toe (hallux)" means complete severance at the metatarsalphalangeal joint.
- "Loss of one arm" means the arm is completely severed at or above the elbow.

- "Loss of one leg" means the leg is completely severed at or above the knee.
- "Loss of speech" means that speech is lost entirely.
- "Hemiplegia" means total paralysis of upper and lower limbs, unilaterally.
- "Paraplegia" means total paralysis of both lower limbs.
- "Quadriplegia" means total paralysis of upper and lower limbs, bilaterally.
- "Uniplegia" means paralysis of one arm or one leg

B400.6150

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of Your Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of Your Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6151

All Options

Common Carrier Benefit If You suffer a Covered Loss due to an Accident which occurs while You are riding in a public conveyance as a fare paying passenger, We increase the benefit payable. In that case, We will pay two times the amount which otherwise applies to the loss.

B400.6154

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from Your home. In that case, We pay up to \$5,000 for costs to prepare and transport Your body to a mortuary chosen by You or an authorized agent. In the event that a Repatriation Benefit is paid under Your Group Term Life Insurance Certificate, no additional benefit will be paid under this Accidental Death and Dismemberment Certificate.

B400.6155

All Options

Exposure If You suffer a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss. If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payments.

B400.6156

All Options

Disappearance You will have a presumed Covered Loss due to an Accident if:

- You are riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- Your body is not found within 365 days of the day the Accident; and
- The Accident occurs while You are covered by this Certificate.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payments.

B400.6157

All Options

Helmet Benefit If You die as a result of a Motorcycle Accident while properly wearing a Helmet and You are the driver and hold a valid driver's license with a Motorcycle endorsement and We determine an Accidental Death and Dismemberment benefit is payable, We will increase Your benefit by the lesser of:

- 50% of the benefit amount; or
- \$25,000.

We must receive evidence that the Employee's death resulted from a Motorcycle Accident, and that the Employee was wearing a Helmet at the time of the Accident. A copy of the police report is required.

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

Helmet: This term means a protective head covering made of a hard material to resist impact and that conforms to the Department Of Transportation helmet certification.

Motorcycle: This term means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver's license to operate the vehicle.

B401.2266

All Options

Workplace Assault If You suffer a Covered Loss due to an Accidental bodily injury caused by a Felonious Act of Violence and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay a Workplace Assault benefit subject to all the terms below:

- A benefit is payable under the Certificate's Employee Basic and Voluntary Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss;

- The Felonious Act of Violence must occur while You are working for Your Employer, at Your Employer's usual place of business, at an alternative work site at the direction of Your Employer, including Your home or a location to which the job requires You to travel;
- The loss did not occur while You were committing a felonious act; and
- The Felonious Act of Violence was not committed by members of Your family or household.

What We Pay: Subject to all the terms of this Certificate, the Workplace Assault Benefit pays the lesser of: (a) 10% of the benefit amount; or (b) \$25,000.

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

- **A Felonious Act of Violence:** This term includes but is not limited to robbery, theft, hijacking, assault and battery, sniping, murder or civil disturbance. The Workplace Assault benefit is subject to all the exclusions under the Accidental Death and Dismemberment benefit, including act of war language.

B401.2185

All Options

Rehabilitation Benefit If You suffer a Covered Loss other than loss of life due to an Accidental bodily injury and We determine an Accidental Death and Dismemberment Benefit is payable, We will pay a Rehabilitation Benefit subject to all of the terms below:

- A benefit is payable under this Certificate's Employee Basic and Voluntary Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life;
- You require rehabilitative training, for which there is an Incurred Expense, due to Your Accidental bodily injury;
- You are trained for another occupation because You cannot perform Your occupation due to the Accidental bodily injury; and
- The expense is incurred within one year of the date of the Accident.

What We Pay: Subject to all the terms of this Certificate, the Rehabilitation Benefit pays the lesser of:

- The expense incurred for rehabilitative training; or
- 5% of the benefit amount payable for the Covered Loss; or
- \$2,500. We pay this benefit in arrears, upon receipt of incurred expense for training. Proof must be submitted within 90 days of the Incurred Expense.

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

Incurred Expense: This term means the actual cost of the

- Training; and
- Materials needed for the training.

B400.6168

All Options

Adaptive Home & Vehicle Benefit

If You suffer a Covered Loss other than loss of life due to an Accidental bodily injury and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay an Adaptive Home and Vehicle Benefit subject to all of the terms below:

- A benefit is payable under this Certificates Employee Basic and Voluntary Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life; and
- The home alteration must be:
 - Made to Your principal residence;
 - Made by a licensed contractor that is not You, Your Spouse, child, parent, sibling or business associate; and
 - Reasonable based on Your residual capabilities; and
- The vehicle modification must be:
 - Made to Your Private Automobile; and
 - Carried out by a licensed technician that is not You, Your Spouse, child, parent, sibling or business associate; and
 - Approved by the Motor Vehicle Department; and
- The expense is incurred within one year of the date of the Accident.

What We Pay: Subject to all the terms of this Policy, the Adaptive Home and Vehicle Benefit pays the lesser of:

- 5% of the Insurance Amount; or
- \$2,500; or
- The actual one-time cost.

We pay this benefit in arrears, upon receipt of incurred expense for the alteration or modification. Proof must be submitted within 90 days of the incurred expense.

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

Incurred Expense: This term means the actual cost (materials and labor) of the alteration and modification.

Private Automobile: This term means a four-wheeled, private passenger car, station wagon, pick-up truck, van or jeep-type automobile which is not being used as a public conveyance.

B400.6160

All Options

Spousal Education And Retraining Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Spousal Education and Retraining Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
 - Universities;
 - Colleges;
 - Trade schools; and
 - Professional schools.

It does not include graduate level programs.

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgment as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the Spouse is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.

- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
 - Cost of books;
 - Cost of other related course materials;
 - Student activity fees; or
 - Room and board.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a Spousal Education and Retraining Benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment Insurance or Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;
- You and Your Spouse share the same place of residence on the date of the Accidental injury which results in the Specified Loss; and
- We receive proof of Your enrollment in an Institute Of Higher Learning. You must:
 - Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
 - Enroll within 12 months of that date.

What We Pay

Subject to all the terms of this Policy, this benefit per academic term will be equal to the lesser of:

- Your Net Tuition Expense for the term;
- 5% of the Basic Accidental Death and Dismemberment Insurance benefit and or Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- \$2,500 And, this benefit is subject to a lifetime maximum of \$20,000.

If this benefit is payable under both a Basic and a Voluntary Certificate, the total benefit paid will not exceed Your Net Tuition Expense for the term.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. The maximum number of benefit payments is based on whether You are enrolled in a part-time or full-time course of study. For full-time study, the maximum number of benefit payments is eight. For part-time study, the maximum number of benefit payments is four.

**Continued Eligibility
For The Spousal
Education And
Retraining Benefit**

We require periodic proof of Your continued enrollment in an Institute Of Higher Learning. And, You must maintain a grade point average of at least 2.0 on a 4.0 scale, or its equivalent. We also require proof, per academic term of:

- Your Tuition Expenses; and
- Any scholarships and grants to which You are entitled.

**When The Spousal
Education And
Retraining Benefit
Ends**

This benefit ends on the earliest of the dates shown below:

- The date You are no longer enrolled in an Institute Of Higher Learning;
- The date You fail to maintain a minimum grade point average as shown above;
- The date You fail to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.

If you die as a result of an Accidental bodily injury and the Spousal Education and Retraining benefit is in effect on the date You die and there is no qualified dependent Spouse who could qualify for this benefit, we will pay a one time benefit of \$500 to the beneficiary in one sum.

B400.6167

All Options

Dependent Child Education Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Dependent Child Education Benefit on behalf of a Qualified Dependent Child subject to all of the terms shown below.

Definitions

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
 - Universities;
 - Colleges;
 - Trade schools; and

- Professional schools.

It does not include graduate level programs

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of: (1) short term memory; (2) orientation to time, place and person; (3) deductive or abstract reasoning; and (4) judgement as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the dependent child is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Dependent Child:** This term means a child who is:
 - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
 - Dependent on You for his or her chief support and maintenance.
- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
 - Cost of books;
 - Cost of other related course materials;
 - Student activity fees; or
 - Room and board.

**When And How The
Dependent Child
Education Benefit
Begins**

We will pay a dependent child education benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment or Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;

- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be 22 years of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in an Institute Of Higher Learning. He or she must be a full-time student, as defined by the institute. And, he or she must:
 - Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
 - Be in the 12th grade and enroll within 12 months of that date.

What We Pay Subject to all the terms of this Policy, this benefit per academic term will be equal to the lesser of:

- The Qualified Dependent Child's Net Tuition Expense for the term;
- 5% of the Basic Accidental Death and Dismemberment Benefit and Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- \$2,500 And, this benefit is subject to a lifetime maximum of \$20,000.

If this benefit is payable under both a Basic and a Voluntary Certificate, the total benefit paid will not exceed the Qualified Dependent Child's Net Tuition Expense for the term.

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. The maximum number of benefit payments is eight.

Continued Eligibility For The Dependent Child Education Benefit We require periodic proof that a child remains a Qualified Dependent Child as shown above. We also require proof, per academic term of:

- His or her Tuition Expenses; and
- Any scholarships and grants to which he or she is entitled.

When The Dependent Child Education Benefit Ends

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in an Institute Of Higher Learning;
- The date the child fails to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.

- The end of a period of six years from the date the first child education benefit payment is made.

If you die as a result of an Accidental bodily injury and the Dependent Child Education benefit is in effect on the date You die and there is no Qualified Dependent Child who could qualify for this benefit, we will pay a one time benefit of \$500 to the beneficiary in one sum.

B400.6172

All Options

Day Care Expense Benefit

If You suffer a Specified Loss due to an Accidental bodily injury, We will pay a Day Care Expense Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Day Care Program:** This term means a program of child care which:
 - Is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and
 - Charges a fee for the care of children.

The term does not include child care provided by a:

- Parent;
- Stepparent;
- Grandparent;
- Sibling;
- Aunt; or

- Uncle.
- **Qualified Dependent Child:** This term means a child who is:
 - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
 - Dependent on You for his or her chief support and maintenance.
- **Specified Loss:** This term means:
 - Loss of life
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Or severe head injury which results in Loss of Cognitive Function.

**When And How The
Day Care Expense
Benefit Begins**

We will pay a day care expense benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Basic Accidental Death and Dismemberment or Voluntary Accidental Death and Dismemberment and Catastrophic Loss due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be under the age of seven of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in a Qualified Day Care Program. His or her enrollment must start within 12 months of the date of the Accidental injury which results in the Specified Loss.

What We Pay

Subject to all the terms of this Policy, this benefit will be equal to the lesser of:

- \$10,000 per year; and
- The actual yearly day care expenses for all of Your Qualified Dependent Children.

If this benefit is payable under both a Basic and a Voluntary Certificate, the total benefit paid will not exceed the yearly day care expenses for all of Your Qualified Dependent Children.

If this benefit is payable as both an Employee Accidental Death and Dismemberment Benefit and a Dependent Accidental Death and Dismemberment Benefit under this Certificate, the total benefit paid will not exceed the yearly day care expenses for all of Your Qualified Dependent Children.

We pay this benefit to the person who has primary responsibility for these expenses.

**Continued Eligibility
For The Day Care
Expense Benefit**

We require periodic proof:

- That a child remains enrolled in a Qualified Day Care Program; and
- Of the child's day care expenses.

**When The Day Care
Expense Benefit
Ends**

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in a Qualified Day Care Program;
- The date We do not receive any required proof as shown above; and
- The end of a period of four years from the date the first day care expense benefit was paid.

If you die as a result of an Accidental bodily injury and the Day Care Expense benefit is in effect on the date You die and there is no Qualified Dependent Child who could qualify for this benefit, we will pay a one time benefit of \$500 to the beneficiary in one sum.

B400.6175

All Options

**DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT
(AD&D) INSURANCE**

B400.6177

All Options

**Dependent Voluntary Accidental Death and Dismemberment
Insurance And Catastrophic Loss Benefits**

B400.6179

All Options

We will pay the benefits described below if a covered dependent suffers an irreversible loss due to an Accident that occurs while he or she is insured under this Certificate. The loss must: (1) be a result of the Accident; and (2) occur within 365 days of the date of the Accident.

B401.2191

All Options

Payment Of Benefits For all Covered Losses, We pay You, if You are living. If You are not living, We will pay this benefit as follows:

If the dependent was Your Spouse, We will pay this benefit in equal shares to the first eligible party or parties in the following order:

- To Your Spouses estate;
- To Your Spouses children in equal shares;
- If no children survive him or her, then to his or her parents in equal shares;
- If no children, or parents survive him or her, then to then to his or her brothers and sisters in equal shares;
- If none of the above parties survive Your Spouse, then to the executors or administrators of Your estate.

If the dependent was Your child, we will pay this benefit in equal shares to the first eligible party or parties in the following order:

- Your childs custodial parent(s);
- If no custodial parent survives him or her, then to Your parents;
- If no custodial parent or Your parents survive him or her, then to Your childs estate;

- If none of the above parties survive him or her and no estate exists, then to the executors or administrators of Your estate;
- If none of the above parties survive him or her, and no estates exist, then to Your child's siblings.

Payment of Funeral Expenses We have the option of paying up to \$500 of this benefit to any person who incurred expenses for your dependent's funeral.

B400.6184

All Options

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Losses Benefits will be paid only for losses listed in the Table of Covered Losses shown below. Your covered dependent's insurance amount is shown in the Accidental Death and Dismemberment Schedule Of Benefits.

Table Of Covered Losses

Covered Loss	Benefit
Loss of life	100% of the Voluntary AD&D insurance amount.
Disappearance	100% of the Voluntary AD&D insurance amount.
Loss of a hand	50% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one arm".
Loss of a foot	50% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "loss of one leg".
Loss of sight in one eye	50% of the Voluntary AD&D insurance amount.
Loss of thumb and index finger of same hand	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".

Loss of four fingers of same hand	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a hand" or "loss of one arm".
Loss of all toes of same foot	25% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Loss of the great toe (hallux)	15% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".

CATASTROPHIC LOSS BENEFITS

Quadriplegia	100% of the Voluntary AD&D insurance amount. No benefit will be paid if benefits have been paid for "Loss of a foot" or "loss of one leg".
Hemiplegia	50% of the Voluntary AD&D insurance amount.
Paraplegia	75% of the Voluntary AD&D insurance amount.
Uniplegia	25% of the Voluntary AD&D insurance amount
Comatose state, in excess of one month	100% of the Voluntary AD&D insurance amount.
Loss of cognitive function	100% of the Voluntary AD&D insurance amount.

Loss of speech and hearing	100% of the Voluntary AD&D insurance amount.
Loss of speech or hearing	50% of the Voluntary AD&D insurance amount.
Loss of one arm or leg	75% of the Voluntary AD&D insurance amount.
Third degree burns covering 75% or more of the body	75% of the Voluntary AD&D insurance amount
Third degree burns covering 50% or more but less than 75% of the body	50% of the Voluntary AD&D insurance amount

B400.6186

All Options

As used here:

- "Loss of cognitive function" means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgment as it relates to awareness of safety.
- "Loss of a hand" means the hand is completely severed at or above the wrist.
- "Loss of a foot" means the foot is completely severed at or above the ankle.
- Loss of all toes of same foot means complete severance at the metatarsalphalangeal joint.
- Loss of the great toe (hallux) means complete severance at the metatarsalphalangeal joint.
- Loss of one arm means the arm is completely severed at or above the elbow.
- Loss of one leg means the leg is completely severed at or above the knee.
- "Loss of hearing" means that hearing in both ears is lost entirely.

- "Loss of sight" means total and permanent loss of sight.
- "Loss of speech" means that speech is lost entirely.
- Loss of thumb and index finger of same hand or Loss of four fingers of same hand means complete severance at the metacarpophalangeal joints of the same hand.
- Loss of all toes of same foot means complete severance at the metatarsalphalangeal joint.
- "Hemiplegia" means total paralysis of upper and lower limbs, unilaterally.
- "Paraplegia" means total paralysis of both lower limbs.
- "Quadriplegia" means total paralysis of upper and lower limbs, bilaterally.
- Uniplegia means total paralysis of one arm or one leg.

B400.6188

All Options

Multiple Losses For more than one Covered Loss due to the same Accident, We will pay up to 100% of the covered dependent's Voluntary Accidental Death and Dismemberment Insurance amount. We will not pay more than 100% of his or her Voluntary Accidental Death and Dismemberment Insurance amount for all losses due to the same Accident, except as shown under the Common Carrier Benefit, Seatbelt And Airbag Benefits and Repatriation Benefit.

B400.6189

All Options

Repatriation Benefit We pay an extra sum for Covered Loss of life due to an Accident which occurs at least 75 miles from the covered dependent's home. In that case, We pay up to \$5,000 for costs to prepare and transport his or her body to a mortuary chosen by You.

B400.7168

All Options

Exposure If the covered dependent suffers a Covered Loss shown in the Table of Covered Losses due to an Accidental bodily injury caused by being unavoidably exposed to the elements, We will pay the amount which otherwise applies to the loss.

If Covered Loss benefits are deemed payable under Exposure, the Covered Loss benefit is only paid once, not in addition to the Exposure payment.

B400.7169

All Options

Disappearance The covered dependent will have a presumed Accidental bodily injury due to an Accident if:

- The covered dependent is riding in a public conveyance that is involved in an Accident;
- As a result of the Accident, the public conveyance is wrecked, sinks, is stranded or disappears;
- The covered dependent's body is not found within 365 days of the day the Accident; and
- The Accident occurs while the covered dependent is covered by this policy.

If Covered Loss benefits are deemed payable under Disappearance, the Covered Loss benefit is only paid once, not in addition to the Disappearance payment.

B400.7170

All Options

Helmet Benefit If the covered dependent dies as a result of a Motorcycle Accident while properly wearing a Helmet and he or she held a valid driver's license with a Motorcycle endorsement and We determine an Accidental Death and Dismemberment Benefit is payable, We will increase the benefit by the lesser of:

- 25% of the benefit amount; or
- \$25,000.

We must receive evidence that the covered dependent's death resulted from a Motorcycle Accident, and that the covered dependent was wearing a Helmet at the time of the Accident. A copy of the police report is required.

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

Helmet: This term means a protective head covering made of a hard material to resist impact and that conforms to the Department of Transportation helmet certification.

Motorcycle: This term means a motor vehicle licensed for use on public highways which requires a Motorcycle endorsement on a driver's license to operate the vehicle.

B401.2192

All Options

Rehabilitation Benefit If the covered dependent suffers a Covered Loss other than loss of life due to an Accidental bodily injury and We determine an Accidental Death and Dismemberment Benefit is payable, We will pay a Rehabilitation Benefit subject to all of the terms below:

- A benefit is payable under this Certificate's Dependent Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life;
- Rehabilitative training is required, for which there is an Incurred Expense, due to the covered dependents Accidental bodily injury;
- The covered dependent is trained for another occupation because he or she cannot perform his or her occupation due to the Accidental bodily injury; and
- The expense is incurred within one year of the date of the Accident.

What We Pay Subject to all the terms of this Certificate, the Rehabilitation Benefit pays the lesser of:

- The expense incurred for rehabilitative training; or
- 5% of the benefit amount payable for the Covered Loss; or
- \$2,500.

We pay this benefit in arrears, upon receipt of incurred expense for training. Proof must be submitted within 90 days of the incurred expense.

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

Incurred Expense This term means the actual cost of the (a) training; and (b) materials needed for the training.

B400.7172

All Options

Adaptive Home And Vehicle Benefit If the covered dependent suffers a Covered Loss other than loss of life due to an Accidental bodily injury and We determine that an Accidental Death and Dismemberment Benefit is payable, We will pay an Adaptive Home and Vehicle Benefit subject to all of the terms below:

- A benefit is payable under this Certificate's Dependent Basic Accidental Death and Dismemberment and Catastrophic Loss Benefit due to a Covered Loss other than loss of life;
- The home alteration must be:
 - Made to the covered dependent's principal residence;
 - Made by a licensed contractor that is not You, Your Spouse, child, parent, sibling or business associate; and
 - Reasonable based on Your residual capabilities;

- The vehicle modification must be:
 - Made to the covered dependent's Private Automobile; and
 - Carried out by a licensed technician that is not You, Your Spouse, child, parent, sibling or business associate; and
 - Approved by the Motor Vehicle Department; and
- The expense is incurred within one year of the date of the Accident.

What We Pay Subject to all the terms of this Certificate, the Adaptive Home and Vehicle Benefit pays the lesser of:

- 5% of the Insurance Amount;
- \$2,500; or
- The actual one-time cost.

We pay this benefit in arrears, upon receipt of the incurred expense for the alteration or modification. Proof must be submitted within 90 days of the incurred expense.

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

Incurred Expense: This term means the actual cost (materials and labor) of the alteration and modification.

Private Automobile: means a four-wheeled, private passenger car, station wagon, pick-up truck, van or jeep-type automobile which is not being used as a public conveyance.

B400.7173

All Options

Spousal Education And Retraining Benefit

If Your covered Spouse suffers a Specified Loss due to an Accidental bodily injury, We will pay You a spousal education and retraining benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
 - Universities;
 - Colleges;
 - Trade schools; and

- Professional schools.

It does not include graduate level programs.

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the You are entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia or
 - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
 - Cost of books;
 - Cost of other related course materials;
 - Student activity fees; or
 - Room and board.

When And How The Spousal Education And Retraining Benefit Begins

We will pay a spousal education and retraining benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Dependent Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;
- You and Your Spouse share the same place of residence on the date of the Accidental injury which results in the Specified Loss; and
- We receive proof of Your enrollment in an Institute Of Higher Learning. You must: (a) be enrolled on the date of the Accidental injury which results in the Specified Loss; or (b) enroll within 12 months of that date.

What We Pay Subject to all the terms of this Certificate, this benefit per academic term will be equal to the lesser of:

- Your Net Tuition Expense for the term;
- 5% of the Dependent Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance Benefit paid as a result of the Specified Loss; and
- \$2,500

And, this benefit is subject to a lifetime maximum of \$20,000

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. The maximum number of benefit payments is based on whether You are enrolled in a part-time or full-time course of study. For full-time study, the maximum number of benefit payments is eight. For part-time study, the maximum number of benefit payments is four.

Continued Eligibility For The Spousal Education And Retraining Benefit We require periodic proof of Your continued enrollment in an Institute Of Higher Learning. And, You must maintain a grade point average of at least 2.0 on a 4.0 scale, or its equivalent. We also require proof, per academic term of:

- Your Tuition Expenses; and
- Any scholarships and grants to which You are entitled.

When The Spousal Education And Retraining Benefit Ends This benefit ends on the earliest of the dates shown below:

- The date You are no longer enrolled in an Institute Of Higher Learning;
- The date You fail to maintain a minimum grade point average as shown above;
- The date You fail to furnish any required proof as shown above;
- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.

B400.7174

All Options

Dependent Child Education Benefit

If Your covered Spouse suffers a Specified Loss due to an Accidental bodily injury, We will pay you a Dependent Child Education Benefit on behalf of a Qualified Dependent Child subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Institute Of Higher Learning:** This term includes, but is not limited to:
 - Universities;
 - Colleges;
 - Trade schools; and
 - Professional schools

It does not include graduate level programs.

- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- **Net Tuition Expense:** This term means Tuition Expense less any scholarships or grants to which the Qualified Dependent Child is entitled.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Dependent Child:** This term means a child who is:
 - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship;
 - Dependent on You for his or her chief support and maintenance.
- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Severe head injury which results in Loss of Cognitive Function.
- **Tuition Expense:** This term means charges incurred for courses or lab fees. It does not include:
 - Cost of books;

- Cost of other related course materials;
- Student activity fees; or
- Room and board.

**When And How The
Dependent Child
Education Benefit
Begins**

We will pay a Dependent Child Education Benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Dependent Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be 22 years of age or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in an Institute Of Higher Learning. He or she must be a full-time student, as defined by the institute. And, he or she must:
 - Be enrolled on the date of the Accidental injury which results in the Specified Loss; or
 - Be in the 12th grade and enroll within 12 months of that date.

What We Pay

Subject to all the terms of this Certificate, this benefit per academic term will be equal to the lesser of:

- The Qualified Dependent Child's Net Tuition Expense for the term;
- 5% of the Dependent Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance benefit paid as a result of the Specified Loss; and
- \$2,500 And, this benefit is subject to a lifetime maximum of \$20,000

We pay this benefit to the person who has primary responsibility for these expenses.

This benefit is paid per academic term. The maximum number of benefit payments is eight.

**Continued Eligibility
For The Dependent
Child Education
Benefit**

We require periodic proof that a child remains a Qualified Dependent Child as shown above. We also require proof, per academic term of:

- His or her Tuition Expenses; and
- Any scholarships and grants to which he or she is entitled.

**When The
Dependent Child
Education Benefit
Ends**

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in an Institute Of Higher Learning;
- The date the child fails to furnish any required proof as shown above;

- The date the lifetime maximum benefit is paid; and
- The date the maximum number of benefit payments have been made.
- The end of a period of six years from the date the first child education benefit is made.

B400.7175

All Options

Day Care Expense Benefit

If Your covered Spouse suffers a Covered Loss due to an Accidental bodily injury, We will pay you a Day Care Expense Benefit subject to all of the terms shown below.

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

- **Hemiplegia:** This term means total paralysis of upper and lower limbs, unilaterally.
- **Loss Of Cognitive Function:** This term means a significant decline or loss in intellectual aptitude. Such loss must result from an Accidental injury. And, it must be supported by clinical proof or standardized tests that precisely measure decline in the areas of:
 - Short term memory;
 - Orientation to time, place and person;
 - Deductive or abstract reasoning; and
 - Judgement as it relates to awareness of safety.
- **Paraplegia:** This term means total paralysis of both lower limbs.
- **Quadriplegia:** This term means total paralysis of upper and lower limbs, bilaterally.
- **Qualified Day Care Program:** This term means a program of child care which:
 - Is provided in a facility that is licensed as a day care center or is operated by a licensed day care provider; and
 - charges a fee for the care of children. The term does not include child care provided by a:
 - Parent;
 - Stepparent;
 - Grandparent;
 - Sibling;
 - Aunt; or

- Uncle.

- **Qualified Dependent Child:** This term means a child who is:
 - Your biological child, lawfully adopted child, stepchild, or any other child who is living with You in a regular parent-child relationship; and
 - Dependent on You for his or her chief support and maintenance.
- **Specified Loss:** This term means:
 - Loss of life;
 - A comatose state which lasts for a period in excess of one month;
 - Spinal cord injury which results in Hemiplegia, Paraplegia or Quadriplegia; or
 - Severe head injury which results in Loss of Cognitive Function.

**When And How The
Day Care Expense
Benefit Begins**

We will pay a Day Care Expense Benefit when all of the conditions shown below are met:

- A benefit is payable under this Certificate's Dependent Voluntary Accidental Death and Dismemberment and Catastrophic Loss Insurance due to a Specified Loss;
- On the date of the Accidental injury which results in the Specified Loss, the Qualified Dependent Child must be under the age of seven or younger; and
- We receive proof of the Qualified Dependent Child's enrollment in a Qualified Day Care Program. His or her enrollment must start within 12 months of the date of the Accidental injury which results in the Specified Loss.

What We Pay

Subject to all the terms of this Certificate, this benefit will be equal to the lesser of:

- \$10,000 per year; and
- The actual yearly day care expenses for all of Your Qualified Dependent Children.

If this benefit is payable as both an Employee Accidental Death and Dismemberment Benefit and a Dependent Accidental Death and Dismemberment Benefit under this Certificate, the total benefit paid will not exceed the yearly day care expenses for all of Your Qualified Dependent Children.

We pay this benefit to the person who has primary responsibility for these expenses.

**Continued Eligibility
For The Day Care
Expense Benefit**

We require periodic proof:

- That a child remains enrolled in a Qualified Day Care Program; and
- Of the child's day care expenses.

**When The Day Care
Expense Benefit
Ends**

This benefit ends on the earliest of the dates shown below:

- The date the child is no longer a Qualified Dependent Child as shown above;
- The date the child is no longer enrolled in a Qualified Day Care Program;
- The date We do not receive any required proof as shown above; and
- The end of a period of four years from the date the first day care expense benefit was paid.

B400.7176

CLAIM PROVISIONS

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine Your eligibility for benefits under this Plan.

We will:

- Obtain only such information that is necessary to evaluate a claim for benefits. This information will be obtained as set forth herein with respect to notice and proofs of loss.
- Consider and interpret the terms of this Plan and all information obtained by Us and submitted that relates to a claim for benefits and make a determination based on that information and in accordance with the terms of this Plan and applicable California state law.
- If a claim is approved, review the determination as often as is reasonably necessary to determine continued eligibility for benefits.
- If a claim is denied, provide the claimant within a reasonable period of time a written notification of an adverse determination. Such notification will include the specific reason(s) for the adverse determination.

Notice of Claim: Written notice of intent to file a claim under this Certificate must be sent to Us within 20 days of the date of the loss, or as soon thereafter as is reasonably possible. This Notice should include the name of the insured and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. For details, You can call Us at 1-800-525-4542.

Claim Forms: We will furnish forms for filing proof of death within 15 days of receipt of Notice. If we do not furnish the forms on time, We will accept a written Notice and adequate proof of death that is the basis of the claim as Proof of Loss.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of Your legal capacity, later than one year from the time proof is otherwise required.

Proof of Loss and other claim data should be submitted to:

The Guardian Life Insurance Company of America

Group Life Claims Department

P.O. Box 981573

El Paso, TX 79998-1573

Time of Payment of Claim: We will pay the Group Accidental Death & Dismemberment Insurance Benefit immediately upon receipt of written Proof of Loss.

Legal Actions: No legal action against Guardian related to this Certificate may be brought until 60 days from the date Proof of Loss has been given as shown above. No legal action may be brought against Guardian related to claims for benefits under this Certificate after three years from the date of the final benefit determination.

B401.2193

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.7183

All Options

Accident This term means an unexpected event or occurrence, which results in bodily injury or death while a Covered Person is insured by this Certificate. The term Accident does not include a Sickness.

B401.2194

All Options

Active Work or Actively At Work These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.7186

All Options

Certificate This term means this Certificate of Coverage, including any riders and enrollment forms that may be attached to this Certificate.

B400.7188

All Options

Covered Loss This term means loss due to an Accident while a Covered Person is insured by this Certificate and as outlined in the Table of Covered Losses.

B400.7189

All Options

Covered Person This term means the Employee and dependents who are insured by this Certificate.

B400.7190

All Options

Domestic Partner This term means Your domestic partner who is registered with the California Secretary of State.

B401.2196

All Options

Effective Date The date the Certificate goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Certificate as requested by the Policyholder and approved by Us and in force and effect as stated on the cover page of the Certificate of Coverage.

B400.7192

All Options

Eligibility Date This term means the earliest date a Covered Person is eligible for coverage under this Certificate, and he or she has satisfied all requirements for coverage to begin, as required by this Certificate.

- For Employee coverage, this term means the earliest date You are eligible for coverage under this Certificate.
- For an Employee in Active Work who had completed any waiting period required by the Employer as of the Effective Date of this Certificate, the Eligibility Date means the Effective Date of this Certificate.
- For an Employee in Active Work as of the Effective Date of this Certificate who has not completed any waiting period required by the Employer, the Eligibility Date will be the first date following the completion of the required waiting period.
- For an Employee hired on or after the Effective Date of this Certificate, the Eligibility Date will be the later of the Employee's date of hire, or the first date following the completion of any waiting period required by the Employer.

If this plan requires Employees to elect coverage under this Certificate, the Eligibility date will be the later of:

- The Employee's date of hire;
- The first date following the completion of any waiting period required by the Employer; or
- The approval by Us in writing of any coverage for which You were required to provide Proof of Insurability.

For dependent coverage, this term means the earliest date on which:

- You have Initial Dependents; and
- Are eligible for dependent coverage.

B400.7193

All Options

Employee This term means a person who works for the Employer at the Employer's place of business and whose income is reported to the United States Internal Revenue Service, and/or a state, for tax purposes. Partners and proprietors will also be treated as Employees if the eligibility requirements are met.

B400.7195

All Options

Employer This term means RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA: EXTENDED CARE HOSPITAL OF WESTMINSTER .

B400.7196

All Options

Enrollment Period This term means the 31 day period which starts on the date You first become eligible for coverage.

B400.7197

All Options

Full-Time This term means You are not a part time Employee as defined by Your Employer and the average number of hours You worked for the six months prior to the last full day worked was at least 20 hours per week at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of occupational duties.

B401.3005

All Options

Initial Dependents This term means those eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your Initial Dependents.

B400.7199

All Options

Legally Intoxicated "Intoxicated" means that the Covered Person's blood alcohol content meets or exceeds the percentage or amount of blood alcohol content that creates a legal presumption of intoxication under the laws of the state or territory in which the loss occurred for operating a motor vehicle under the influence, regardless of whether the Covered Person was operating a motor vehicle at the time the loss occurred.

B400.7219

All Options

Month or Months or Monthly These terms mean a consecutive 30 day period.

B400.7220

All Options

Newly Acquired Dependent This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B400.7221

All Options

Policy or Plan This term means the Group Accidental Death and Dismemberment Coverage described in the Policy and in this Certificate.

B400.7223

All Options

Proof Of Insurability This term means the completion of an evidence of insurability form, which shows that a person is insurable.

B400.6388

All Options

Proof of Loss This term means the documents that We use to substantiate an accidental death and dismemberment claim. Examples of documents used for Proof of Loss include:

- An original certified finalized death certificate;
- The beneficiary designation in effect at the time of death;
- Enrollment information documenting that the insured was properly enrolled for the amount of coverage claimed;
- A fully completed claim form; and
- Any additional information deemed necessary during the course of Our claim investigation. This may include, but is not limited to, an autopsy report, investigative reports, toxicology reports and medical records.

B401.2197

All Options

Third degree Burn This term means a burn involving the full thickness of skin including the tissue beneath the skin; burns in which both the epidermis and dermis are destroyed with damage extending into underlying tissues.

B400.7227

All Options

Spouse This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include Your Domestic Partner.

B401.2198

All Options

We, Us and Our These terms mean The Guardian Life Insurance Company of America.

B400.7229

All Options

You or Your These terms mean the insured Employee.

B400.7230

EXCLUSIONS

Conditions that are not considered Covered Losses and that are not covered under the terms of this Certificate.

- Willful self-injury, suicide, or attempted suicide while sane or insane;
- Sickness, disease, mental infirmity, or result of any medical or surgical treatment;
- Infection, except pyogenic infections which result from a bodily injury or bacterial infections which result from the unintentional ingestion of contaminated substances;
- The intentional or voluntary inhalation or ingestion of gas, chemical, solvent, poison or other substances not intended for internal consumption;
- An injury the Covered Person suffers while taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony, as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense;
- Injury suffered while travelling on any type of aircraft if the Covered Person is an instructor or crew member; or has any duties at all on that aircraft;
- Injury suffered in declared or undeclared war or act of war or armed aggression;
- Injury suffered while the Covered Person is a member of any armed force;
- Injury suffered while the Covered Person is Legally Intoxicated; or
- Injury suffered while the Covered Person is voluntarily using a controlled substance, unless:
 - It was prescribed for the Covered Person by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

B401.2787

All Options

GROUP ACCIDENTAL DEATH AND DISMEMBERMENT
SCHEDULE OF BENEFITS

B400.7846

All Options

Employee Basic Accidental Death And Dismemberment (AD&D)
Insurance Schedule

B400.7859

All Options

Basic AD&D Insurance Amount

The Insurance Amount is \$20,000.00

B400.7860

All Options

Reduction of Basic AD&D Insurance Amount Based on Age

If You are less than age 70 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70, but before You reach age 75.

If You are less than age 75 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 75, by 60% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 75, but before You reach age 80.

If You are less than age 80 when Your insurance under this Policy starts, Your insurance amount will be reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 80, by 65% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 80.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.7900

All Options

Proof of Insurability Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements Proof Of Insurability requirements apply to Basic Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

If You:

- Do not meet this Policy's enrollment requirement within 30 days after You first become eligible; or

- Enroll after You previously had coverage which ended because You failed to make a required payment,

We will require that You provide Proof Of Insurability. And, You will not be covered until We approve that proof in writing.

If Your Active Full-Time Work ends before You meet any Proof Of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B400.8032

All Options

Employee Voluntary Accidental Death And Dismemberment (AD&D) Insurance Schedule

B400.8097

All Options

Initial Election You will be insured under one of the plans of Voluntary Accidental Death and Dismemberment Insurance which is equal to 100% of the Voluntary Term Life amount not to exceed \$500,000.00. You may only be insured under one plan at a time. You must notify the Employer of your election and pay the required premium.

B400.8100

All Options

Changing Election You may switch to another benefit any time the Voluntary Term Life amount is changed. You must notify the Employer of the switch and the amount must be 100% of the Voluntary Term Life amount.

B400.8104

All Options

Voluntary AD&D Insurance Amount *Plan A*
You may elect amounts of Voluntary Accidental Death and Dismemberment Insurance in increments of \$10,000.00, but your amount may not be less than \$10,000.00 and may not exceed \$500,000.00.

B400.8127

All Options

Annual Election After You first enroll for Employee Voluntary Accidental Death and Dismemberment Insurance, You may choose to increase Your amount of Voluntary Accidental Death and Dismemberment Insurance by an amount not to exceed an increase of \$50,000 as shown above. This option is available during the Voluntary Accidental Death and Dismemberment enrollment period described above. Proof Of Insurability will not be required unless the insurance amount exceeds the amount of Voluntary Accidental Death and Dismemberment Insurance for which Proof Of Insurability is required as shown below.

If Proof Of Insurability is required and has been submitted and approved by Us, Proof of Insurability for additional increases will be required on the second anniversary of the date we approve such coverage.

If Proof Of Insurability is required and has been declined, You will not be eligible for additional annual increases without submitting Proof Of Insurability for them, and then if such increases are approved by Us in writing.

B400.9092

All Options

Family Status Change You may request a change to your Voluntary Accidental Death and Dismemberment Insurance coverage if you have experienced a Family Status Change.

A Family Status Change includes one or more of the following:

- Marriage or divorce;
- Death of a Spouse or child;
- Birth or adoption of a child;
- Your Spouse's termination of employment or a change in Your Spouse's employment that results in the loss of group coverage.

The term "marriage" may also refer to civil unions and domestic partnerships, as recognized by the jurisdiction in which You reside.

If a change in Family Status occurs, You may request an increase to Your Voluntary Accidental Death and Dismemberment Insurance amount or the addition of Employee Voluntary Accidental Death and Dismemberment Insurance for which You were not previously insured. You may also request an increase or the addition of dependent Spouse or dependent child Voluntary Accidental Death and Dismemberment Insurance for your living eligible dependents. You must provide proof of the Family Status Change and request the change to Your Voluntary Accidental Death and Dismemberment Insurance in writing within 31 days after the date of the Family Status Change as described below.

B400.9096

All Options

Reduction of Voluntary AD&D Insurance Amount Based on Age

If You are less than age 70 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 70, by 35% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 70, but before You reach age 75.

If You are less than age 75 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 75, by 50% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 75, but before You reach age 80.

If You are less than age 80 when Your insurance under this Plan starts, Your insurance amount is reduced at 12:01 A.M. Standard Time for Your place of residence on the date You reach age 80, by 65% of the amount which otherwise applies to Your classification. But in no case will such reduced amount be less than \$1,000.00. This reduction also applies to Your initial insurance amount if Your insurance starts after You reach age 80.

The reduced amount is in place of the amount which otherwise applies to Your classification.

B400.9129

All Options

Proof of Insurability

Depending on the coverage selected, or as otherwise required in this Certificate, You, Your Spouse and/or Dependents may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person applying for coverage requiring Proof of Insurability is referred to as "Applicant."

To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that We may determine whether the Applicant is insurable, according to Our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's health and medical history; prescription history; records relating to treatment, diagnostic testing, hospitalization and the like; and records pertaining to Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant submit Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that we may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

Proof Of Insurability Requirements

Proof Of Insurability requirements apply to Voluntary Accidental Death and Dismemberment Insurance. Such requirements may apply to the full insurance amount, or just part of it, as outlined below. When Proof Of Insurability requirements apply, it means You must submit to Us Proof that You are insurable, and We must approve the Proof in writing before the insurance, or the specified part becomes effective.

We require Proof of Insurability as follows:

B400.9141

All Options

Except as provided for annual election, We require Proof of Insurability before You switch from Your current increment of Voluntary Accidental Death and Dismemberment Insurance to an increment which provides a greater amount of insurance.

B400.9179

All Options

We require Proof of Insurability before We will insure You if You enroll for Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Certificate.

B400.9184

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed \$100,000.00.

B400.9188

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed \$50,000.00, if Your scheduled Voluntary Accidental Death and Dismemberment Insurance effective date is after You reach age 65.

B400.9191

All Options

We require Proof of Insurability for all amounts of Voluntary Accidental Death and Dismemberment Insurance which exceed \$10,000.00, if Your scheduled Voluntary Accidental Death and Dismemberment Insurance effective date is after You reach age 70.

B400.9191

All Options

Dependent Voluntary Accidental Death and Dismemberment Schedule

B400.9308

All Options

Initial Election You may choose the plan of dependent Spouse Voluntary Accidental Death and Dismemberment Insurance and the plan of dependent child Voluntary Accidental Death and Dismemberment Insurance shown below. You must notify the Employer of Your election and pay the required premium.

B400.9309

All Options

Voluntary *Plan A*
Dependent Spouse Insurance Amount You may elect amounts of Voluntary dependent spouse Accidental Death and Dismemberment Insurance in increments of \$5,000.00, but the amount may not be less than \$5,000.00 and may not exceed \$250,000.00.

B400.9318

All Options

Voluntary *Plan A*
Dependent Child Insurance Amount

Child's Age At Death	Insurance Amount
From Birth but less than 14 days	\$500.00
At least 14 days but less than 26 years	\$2,000.00

B401.2800

All Options

Voluntary Dependent Child Insurance Amount	Plan B Child's Age At Death	Insurance Amount
	From Birth but less than 14 days	\$500.00
	At least 14 days but less than 26 years	\$5,000.00
		B401.2800

All Options

Voluntary Dependent Child Insurance Amount	Plan C Child's Age At Death	Insurance Amount
	From Birth but less than 14 days	\$500.00
	At least 14 days but less than 26 years	\$10,000.00
		B401.2800

All Options

In no event may the insurance amount of a dependent Spouse exceed 50% of Your insurance amount.

B401.2814

All Options

In no event may the insurance amount of a dependent child exceed 100% of Your insurance amount.

B400.9343

All Options

Reduction of Dependent Voluntary Accidental Death and Dismemberment Insurance Amount based on Age	Your dependent benefits are reduced in the same manner as Your benefits. The dependent reductions are based on Your age.	B400.9363
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All Options

Proof Of Insurability Requirements	Depending on the coverage selected, or as otherwise required in this Certificate, Your Spouse and Dependent Children may be required to supply proof that the person applying for coverage is insurable for the amount and type of coverage selected. This requirement is called Proof of Insurability. For purposes of this section, any person apply for coverage requiring Proof of Insurability is referred to as "Applicant."
	To determine if the Applicant is required to submit Proof of Insurability for the type and amount of coverage sought, please see below.

Any applicant required to submit Proof of Insurability is required to complete and submit to Us an Enrollment/Change form. We may also require the completion of additional forms so that we may determine whether the Applicant is insurable according to our underwriting standards for the amount and type of coverage applied for. To determine if the Applicant is insurable, We may also need to obtain and review the Applicant's:

- Health and medical history;
- Prescription history;
- Records relating to treatment, diagnostic testing, hospitalization; and
- Records pertaining to the Applicant's driving and motor vehicle history.

No coverage requiring Proof of Insurability will become effective unless and until it is approved by Us in writing. Our receipt of any premiums associated with coverage requiring Proof of Insurability does not waive or modify any requirement that must be satisfied for coverage to begin, including but not limited to the requirement that the Applicant provide Proof of Insurability. In the event that any premiums are overpaid, Our only obligation is to return the amount of overpaid premiums.

The Policyholder, or its designee, must give Us complete and accurate information so that We may determine:

- Who is insured;
- The type and amount of coverage for which someone is insured; and
- Any other information required so that Guardian may meet its obligations under the Policy.

We require Proof of Insurability as follows:

B400.9364

All Options

We require Proof Of Insurability that a dependent is insurable if You:

- Enroll a dependent, submit the dependent's signed health statement, and agree to make the required payments after the end of the Enrollment Period;
- In the case of a Newly Acquired Dependent, other than the first newborn child, have other eligible dependents who You have not elected to enroll; or
- In the case of a Newly Acquired Dependent, have other eligible dependents whose coverage previously ended because You failed to make the required contributions, or otherwise chose to end such coverage.

B400.9367

All Options

A dependent is not covered by any part of this Policy that requires such proof until You give Us this proof and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependents will not be covered by this Policy again until You give Us new proof that they are insurable and We approve that proof in writing.

B400.9368

All Options

We require Proof of Insurability before We will insure any dependent Spouse who is enrolled for dependent Spouse Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Policy.

B400.9373

All Options

We require Proof of Insurability for any amount of dependent Voluntary Accidental Death and Dismemberment Insurance in excess of \$25,000.00 with respect to a dependent Spouse.

B400.9376

All Options

We require Proof of Insurability for any amount of dependent Voluntary Accidental Death and Dismemberment Insurance In excess of \$10,000.00 with respect to a dependent Spouse, if the dependent Spouse's scheduled dependent Voluntary Accidental Death and Dismemberment effective date is after he or she reaches age 65.

B400.9375

All Options

We require Proof of Insurability before We will insure any dependent child who is enrolled for dependent child Voluntary Accidental Death and Dismemberment Insurance after the time allowed for enrolling as specified in this Policy.

B400.9481

All Options

Changes to Insurance

B400.9564

All Options

Changes In Insurance Amounts If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

B400.9568

All Options

Changes In Insurance Classification If Your classification changes, insurance will not be changed to the new amount until the first day on which You are:

- Actively At Work on a Full-Time basis; and
- Make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of insurance is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become insured for the larger amount, You must:

- Make the required contribution for the new amount; and
- Furnish Proof Of Insurability to Us, which We approve in writing.

If the insurance amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

B400.9570

CERTIFICATE RIDER - Seatbelt and Airbag Benefit

This Rider is effective as of the effective date of the Employee's Certificate. If this Rider is added to an inforce Certificate, the Rider becomes effective on its issue date. This Rider amends the Certificate by the addition of the following:

Terms not specifically defined within this Rider are defined in the Certificate.

**Employee Basic and Voluntary
Accidental Death and Dismemberment Insurance
and Dependent Voluntary Accidental Death
and Dismemberment Insurance
Seatbelt and Airbag Benefit**

This rider applies to Your Basic and Voluntary Accidental Death and Dismemberment Insurance and dependent Voluntary Accidental Death and Dismemberment Insurance.

Seatbelt And Airbag Benefits If You die as a result of an automobile Accident while properly wearing a seatbelt, We will increase Your Accidental Death and Dismemberment Benefit amount by \$10,000. And, if You die as a result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase Your Accidental Death and Dismemberment Benefit amount by an additional \$5,000, for a total increase of \$15,000.

Notice of Claim: You must send Us a request which includes written proof that You were properly wearing a seatbelt. A law enforcement official investigating the accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits. We must approve such proof in writing before this benefit is paid.

Proof of Loss: You must send written Proof of Loss to Our designated office within 90 days of the loss.

If We cannot determine that You were wearing a seatbelt at the time of the Accident, We will increase Your Accidental Death and Dismemberment Benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident resulting in Your death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your Basic and Voluntary Accidental Death and Dismemberment Insurance and Basic and Voluntary Group Term Life Insurance and may not exceed \$30,000.

Late Notice and Proof of Loss: We will not void or reduce Your claim if we do not receive Notice and Proof of Loss within the required time. In that case, Notice and Proof of Loss must be sent as soon as reasonably possible.

Proof of loss and other claim data should be submitted to:

**The Guardian Life Insurance Company of America
Group Life Claims Department
P.O. Box 981573
El Paso, TX 79998-1573**

Exclusions This Certificate Rider does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While You are Legally Intoxicated;
- While You are voluntarily using a controlled substance, unless:
 - It was prescribed for You by a Doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While You were intentionally or voluntarily inhaling or ingesting a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

Dependent Seatbelt and Airbag Benefit

**Seatbelt And Airbag
Benefits**

If Your dependent dies as a result of an automobile Accident while properly wearing a seatbelt, We will increase his or her Voluntary Accidental Death and Dismemberment Benefit amount by \$5,000. And, if Your dependent dies as a result of an automobile Accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, We will increase his or her Voluntary Accidental Death and Dismemberment Benefit amount by an additional \$2,500, for a total increase of \$7,500.

You are responsible for providing proof that Your dependent was properly wearing a seatbelt. A law enforcement official investigating the Accident must certify that the seatbelt was properly fastened and that the automobile in which the deceased was traveling was equipped with airbags. A copy of such certification must be submitted to Us with the claim for benefits.

If We cannot determine that Your dependent was wearing a seatbelt at the time of the automobile Accident resulting in his or her death, We will increase Your dependent Accidental Death and Dismemberment Benefit amount by \$1,000.

If We determine that a seatbelt was not worn at the time of the automobile Accident resulting in Your dependent's death, or if the required official report is not provided, no Seatbelt or Airbag Benefit will be paid.

The total amount payable for the Seatbelt and Airbag Benefit under Your dependent Voluntary Accidental Death and Dismemberment Insurance and Voluntary Group Term Life Insurance may not exceed \$15,000 for each covered dependent.

Exclusions This Policy does not pay a Seatbelt or Airbag Benefit for loss of life caused by, or related to an Accident occurring:

- While Your dependent is Legally Intoxicated;
- While Your dependent is voluntarily using a controlled substance, unless:
 - It was prescribed for the dependent by a doctor; and
 - It was used as prescribed.

A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

- While Your dependent intentionally or voluntarily inhales or ingests a gas, chemical, solvent, poison or other substances not intended for internal consumption; or
- During Your dependent's commission of, or attempt to commit a felony as defined per the laws in the jurisdiction in which the felony was committed or attempted, or as defined under federal law if the offense charged was a federal offense.

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B401.2205

CERTIFICATE RIDER

This Rider is effective on the Policy Date. This Rider amends the Certificate by the replacement of the Incontestability provision to the following:

Time Limit On Certain Defenses

After the Policy has been in force for a period of two years, no statements of the Policyholder contained in the application, and no statement relating to insurability made by any Employee eligible for coverage under the Policy shall be used to deny a claim or in contesting the validity of the insurance with respect to which such statement was made after the insurance has been in force prior to the contest for a period of two years during the lifetime of the person with respect to whom any such statement was made.

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

Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B439.0618

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** and **Domestic Partner** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0243

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

**Assistance with
Questions**

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

**Accidental Death
and
Dismemberment
Insurance Claims
Procedure**

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

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

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

Definitions

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

**Timing for Initial
Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

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

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

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

**Adverse Benefit
Determination of
Accidental Death
and
Dismemberment
Insurance Claims**

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

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

B997.0242

All Options

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

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

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

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

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

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

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

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

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B997.0243

All Options

Appeals of Adverse Determinations for Waiver of Premium

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

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

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

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

B997.0244

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017
1-800-273-3330

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

The Group Dental Coverage described in this Evidence of Coverage is attached to the group policy "Policy" effective December 1, 2016. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Policy or under any other policy providing similar or identical benefits issued to the Policyholder by Us.

Managed Dental Care (MDC) of California is a California corporation, licensed as a Knox-Keene Health Care Service Plan under applicable California law, whose primary purpose is to operate a dental care service plan.

MANAGED DENTAL CARE PLAN

GROUP CONTRACT FOR PREPAID DENTAL SERVICES

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHAT IT COVERS, LIMITS, AND EXCLUDES.

We certify that the Employee to whom this Evidence of Coverage is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of the Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee is not covered by any part of the Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA: EXTENDED CARE HOSPITAL OF WESTMINSTER

Group Policy Number: 00531743

Effective Date: December 1, 2016
Managed Dental Care of California

A handwritten signature in black ink, appearing to read "Jill Purcell". The signature is fluid and cursive, with the first name "Jill" being more prominent.

Jill M. Purcell, President

A handwritten signature in black ink, appearing to read "Thomas S. Barnes". The signature is fluid and cursive, with the last name "Barnes" being more prominent.

Thomas S. Barnes, Controller

B425.1256

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Option F

GENERAL PROVISIONS

Applicable Benefits

This Evidence of Coverage may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

B425.0637

Option F

Public Policy Committee

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

B425.0638

Option F

Confidentiality

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

You may contact Our customer services department at the address below to request a copy of the Policy's confidentiality statement. The confidentiality statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

We will direct all confidential communications regarding your receipt of Sensitive Services directly to you. Confidential communications include bills, explanation of benefits, claims, information regarding a session, or other communications containing medical information or provider name and address related to dental services, including information relating to Sensitive Services, that you have received. Unless otherwise directed by you, we will communicate confidential information to you by contacting you at the mailing address, email address, or telephone number on file. If you would like to receive confidential communications in a specific form and format or at an alternative location, please submit a request as follows:

Customer Services Department
P.O. Box 25256
Lehigh Valley, PA 18002-5256
1-800-273-3330

We will accommodate and implement requests for confidential communications in the form and format requested by you, if confidential communications are readily producible in the requested form and format or at alternative locations. We will acknowledge your request for a confidential communication and advise you of the status. We will provide you with confidential communications within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt of a request by mail. Your request for a confidential communication will be valid until you revoke your request, or you submit a new request for a confidential communication.

We will not disclose medical information related to Sensitive Services you receive to your policyholder, the primary subscriber, or any other member, absent your express written authorization to do so. You are not required to obtain authorization from your policyholder, the primary subscriber, or any other member in order for you to receive Sensitive Services or to submit a claim for Sensitive Services.

B425.1254

Option F

Limitation of Authority

Only Our President, a Vice President or a Secretary has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Evidence of Coverage is to be issued;
- Waive or alter any contract, Policy or Evidence of Coverage, or any of Our requirements;
- Bind Us by any statement or promise relating to the Policy issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

B425.0640

Option F

Incontestability

All statements made on Your enrollment form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. No statement contained in Your enrollment form will void Your coverage or reduce Your benefits after Your coverage has been in force for two years. Within the first two years of issuance of coverage under this Policy, We may rescind Your coverage based on any fraudulent statement or intentional misrepresentation of material fact made on Your signed enrollment application.

The statements and information contained in the Your enrollment form are represented by You to be true and correct and incorporated into the Policy. You also recognize that MDC has issued the Policy in reliance on those statements and information. The Policy replaces and cancels all other contracts, if any, issued to You by Us.

In the event Your coverage is rescinded, We will refund premiums paid for the periods such coverage is void. The premium paid by You will be sent to Your last known address on file with the Employer or Us.

B425.1024

Option F

Language Assistance

As an MDC Member, You have a right to free language assistance services, including interpretation and translation services. MDC collects and maintains Your language preferences, race, and ethnicity so that We can communicate more effectively with Our Members. If You require spoken or written language assistance or would like to inform MDC of Your preferred language, please contact Us at 1-800-273-3330. TDD/TTY for the hearing impaired is available through 1-800-947-6644.

B425.1026

Option F

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Option F

Enrollment Procedures

You may enroll for dental coverage by:

- Completing and signing the appropriate enrollment form and any additional material required by Your Policyholder.
- Returning the enrollment material to your Policyholder. Your Policyholder will forward these materials to Us.

The enrollment materials require You to select a Primary Care Dentist ("PCD") for each Member. After Your enrollment material has been received by Us, We will determine if a Member's selected PCD is available under Your Policy. If the PCD is available under the Policy, the selected Dentist will be assigned to the Member as his or her PCD. If a Member's selection is not available, an alternate Dentist will be assigned as the PCD. A Member need only contact his or her assigned PCD's office to obtain services.

We will issue You and Your dependents, either directly or through Your Policyholder's representative, an ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

B425.1038

Option F

Open Enrollment Period

If You do not enroll Yourself or Your eligible dependents for dental coverage under this Policy within 30 days of: a) the date of becoming eligible or b) the date of a Qualifying Event, You must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every 12 months after this Policy's Effective Date, or at time intervals mutually agreed upon by Your Policyholder and Us.

Enrollment is for a minimum of 12 consecutive months while You are eligible. Voluntary termination from this Policy will only be permitted during the open enrollment period.

If after initial enrollment You, or one of Your dependents disenroll from the Policy before the open enrollment period, the Member may not re-enroll until the next open enrollment period which occurs after the Member has been without coverage for one full year.

B425.1027

Option F

Employee Eligibility

You are eligible for dental coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for dental coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Evidence of Coverage.

B425.0656

Option F

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
 - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
 - A child who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Employee for support and maintenance, may remain eligible for dependent benefits past the age limit, subject to the following:

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

Eligible dependent does not include anyone who is insured under this Policy as the Employee.

B425.1047

Option F

When Coverage Starts

Your Employer will inform You of Your Effective Date under the dental Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the dental Policy as stated in the Conditions Of Eligibility for Group Dental Coverage section; and
- You and Your eligible dependents have enrolled in the dental Policy; and
- Required premiums have been paid.

If you do not enroll by Your Effective Date, Your coverage will begin on:

- The first day of the month following the date enrollment materials are received by Us; or
- The first day of the month after the end of any waiting period Your Policyholder may require; or
- The date you are eligible for the Policy based on the Policyholder's eligibility rules as approved by Us.

B425.0392

Option F

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;

- A non-scheduled work day;
- A day during an approved leave of absence not due to sickness or injury of 90 days or less; or
- A day during a period of absence that is less than 7 days in duration;

And if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day;

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Evidence of Coverage replaced.

B425.0674

Option F

Termination of Coverage

In the event of cancellation by either Us (except in the case of fraud or deception in the use of services or facilities of MDC or knowingly permitting such fraud or deception by another) or You, We shall within 30 days return to You any pro rata portion of fees paid by You which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due.

Termination by You

You may cancel your coverage at any time during the grace period outlined below or by giving Us 31 days advance written notice. This notice must be sent to Our office. The Policyholder will owe Us all unpaid premiums for the period that coverage is in force.

Termination by MDC

We shall have the right to cancel Your coverage upon providing written notice to the Policyholder, who is required to promptly send such notice to You, in the following circumstances:

- Termination by MDC for Non-payment of Premium. We may cancel or decline to renew Your coverage for cause if the Policyholder fails to pay all premiums in accordance with the following terms and conditions:

- A grace period of 30 days, starting after the last date of paid coverage, will be allowed for outstanding premium payments. You will receive a written notice stating the start and end dates of the grace period from the Policyholder.
- If the Policyholder, or another party acting on the Policyholders behalf, makes the necessary premium payment and that payment is received on or before the last day of the grace period, We shall ensure that coverage is not cancelled or not renewed on account of non-payment of such premiums.
- If any premium with respect to the Members covered by the Policy is not paid before the end of the grace period, coverage ends with respect to all Members covered by the Policy immediately following the end of the grace period. You will receive a written notice of end of coverage no later than five (5) business days following the last day of paid coverage from the Policyholder.
- If the Policyholder give Us advance written notice of an earlier termination date during the grace period, Your coverage will end as of such earlier date.
- If Your coverage ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy was in force during the grace period.
- Termination by MDC for Intentional Misrepresentation of Material Fact by You. We may cancel or decline to renew Your coverage if We demonstrate an intentional misrepresentation of a material fact by You or the Policyholder in obtaining Your coverage. You will receive 30 days' advance written notice of cancellation from the Policyholder.
- Termination by MDC for Violation of Material Provision Relating to Employer Contributions or Group Participation Rates. We may cancel or decline to renew Your coverage if the Policyholder violates a material provision of the Policy relating to employer contributions or group participation rates. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC Due to Cessation of Services in the State or Withdrawal of Policy from the Market. Subject to providing 180 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the cancellation or nonrenewal is due to MDC ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this State pursuant to Health and Safety Code section 1365(a)(5). Subject to providing 90 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the MDC withdraws the health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6).

If You believe that Your coverage has been or will be improperly canceled, rescinded, or not renewed, You may file request a review by the Department of Managed Health Care, within 180 days of receipt of the notice of cancellation, pursuant to Section 1368 of the Health and Safety Code. Such request for review may be submitted directly to the Department of Managed Health Care by mail to the attention of the Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725; by phone at 1-888-466-2219/TDD 1-877-688-9891; by fax at 1-916-255- 5241; or online at www.healthhelp.ca.gov. Such review shall be in accordance with Sections 1368 and 1365(b) of the Health and Safety Code.

B425.1029

Option F

When Your Dependent Coverage Ends

Your dependent Coverage will end on the first of the following events:

- When Your Coverage ends.
- When You stop being an eligible Employee under this Evidence of Coverage.
- The date the group Evidence of Coverage ends, or dependent Coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For Your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B425.0692

Option F

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Evidence of coverage carefully for details and discuss with Your Employer or administrator.

B425.0696

Option F

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

B425.0071

Option F

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

B425.0078

Cal-COBRA Continuation Rights

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

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

Under this section, a "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this Policy as: (a) an active, covered Employee; (b) the spouse of an active, covered Subscriber; or (c) the dependent Child of an active covered Employee. A child born to, or adopted by, the covered Employee during a continuation period is also a qualified beneficiary if the child is enrolled in the Policy as a dependent within 30 days of the child's birth or placement for adoption. Any other person who becomes covered under this Policy during a continuation period provided by this section is not a qualified beneficiary.

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

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

If Your Group Health Benefits End: If Your group dental benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if You were not terminated due to gross misconduct. The continuation: (a) may cover You or any other qualified beneficiary; and (b) is subject to "When Continuation Ends."

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to the Employees termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

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

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

An additional 50% of the total premium charge also may be required from the qualified beneficiary by the insurer during this extra 11 month continuation period.

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

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

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

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

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

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

B425.0699

Option F

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this section must notify Your Employer, in writing, of: (a) Your legal divorce or legal separation from Your spouse; or (b) the loss of dependent eligibility, as defined in this Policy, of a dependent.

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

Your Employer's Responsibilities: Your Employer must notify the qualified beneficiary, in writing, of: (a) his or her right to continue this Policy's group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

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

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

Election of Continuation: To continue his or her group dental benefits, the qualified beneficiary must give Your Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from Your Employer as described above. And the qualified beneficiary must pay his or her first month's premium within 45 days by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Policy, or to the Employer if the Employer has contracted with the Policy to perform the administrative services. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

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

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group Policy on a regular basis. It includes any amount that Your Employer would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," Your Employer may require an additional charge of 2% of the total premium charge. If the qualified beneficiary fails to give Your Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

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

- a) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date of the qualifying event;
- b) with respect to a disabled qualified beneficiary who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date of the qualifying event; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act;
- c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a dependent's eligibility, the end of the 36 month period which starts on the date of the qualifying event;
- d) with respect to a dependent whose continuation is extended due to the Employees entitlement to Medicare, while the dependent is on continuation, the end of the 36 month period which starts on the date of the qualifying event;
- e) the date Your Employer ceases to provide any group dental plan to any Employee;
- f) the end of the period for which the last premium is made;
- g) the date he or she becomes covered under any other group dental plan which does not contain any pre-existing condition exclusion or limitation affecting him or her;
- h) the date he or she becomes entitled to Medicare.

B425.0700

Small Employer Group

Applies to Members who are covered under a Policy between Us and a California small employer group with two (2) through nineteen (19) eligible employees.

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

Permanent employees who work at least 20 hours but not more than 29 hours are deemed to be eligible employees if all four of the following apply:

(1) they otherwise meet the definition of an eligible employees except for the number of hours worked; (2) the employer offers the employee health coverage under a health benefit plan; (3) all similarly situated individuals are offered coverage under the health benefit plan; and (4) the employee must have worked at least 20 hours per normal workweek for at least 50% of the weeks in the previous calendar quarter.

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

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

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

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

B425.0701

Option F

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B425.0081

Option F

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B425.0083

Option F

DENTAL BENEFITS

This Policy will cover many of the dental expenses incurred by You and those of Your dependents who are covered under this Policy. We interpret how the Policy is to be administered. What We cover and the terms of coverage are explained below.

B425.0084

Option F

How to Contact Us

Our customer service associates can assist You with benefit coverage questions, resolving problems, selecting or changing a Dentist. A customer service associate can be reached toll free Monday through Friday at 1-888-273-3330 from 8:00 am to 8:00 pm, Pacific Standard Time. An automated service is also provided after hours for eligibility verification.

B425.1030

Option F

Managed Dental Care

This Policy is designed to provide quality dental care while controlling the cost of such care. To do this, the Policy requires Members to seek dental care from Contracted Dentists that belong to the Network.

The Network is made up of Contracted Dentists in the Policy's approved Service Area. A Contracted Dentist is a Dentist that has a participation agreement in force with Us.

When a Member enrolls in this Policy, he or she will get information about current Contracted General Dentists. Each Member must be assigned to a Primary Care Dentist ("PCD"). The PCD will coordinate all of the Member's dental care covered by this Policy. After enrollment, a Member will receive an ID card. A Member must present this ID card or supply the Group Number and Member ID number when he or she goes to their PCD.

All dental services covered by this Policy must be coordinated by the PCD to whom the Member is assigned. What We cover is based on all the terms of this Policy. Please refer to the Schedule of Benefits for Group Dental Coverage information including Covered Dental Procedures and Patient Charges, Benefit Limitations and Exclusions.

B425.1039

Option F

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Schedule of Benefits section of this Evidence of Coverage. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a Patient Charge. Services specifically excluded from this coverage are listed in the section titled Exclusions in the Schedule of Benefits. Please read this section carefully. Dental services performed by a Non-Contracted Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Dental Services.

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

B425.0703

Option F

Choice of Dentists

A Member may choose any available Contracted General Dentist as his or her PCD. A request to change a PCD must be made to Us. Any such change will be effective the first day of the month following approval however, We may require up to 30 days to process and approve such request. All fees and Patient Charges due to the Member's current PCD must be paid in full prior to such transfer.

B425.0088

Option F

Changes in Dentist Participation

We may have to reassign a Member to a different Contracted Dentist if:

- The Member's Dentist is no longer a Contracted Dentist in the Network; or
- We take an administrative action which impacts the Dentist's participation in the Network.

If this becomes necessary, the Member will have the opportunity to request another Contracted Dentist.

If a Member has a dental service in progress at the time of the reassignment, We will, at Our option and subject to applicable law, either:

- Arrange for completion of the services by the original Dentist; or
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service.

B425.0089

Option F

Refusal of Recommended Treatment

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

B425.0090

Option F

Specialty Referrals

A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Contracted Specialist. We will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty services are provided in accordance with the specialty referral policy guidelines described below.

In order for specialty services to be covered by this Policy, the referral policy guidelines stated below must be followed:

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a Contracted Specialist is required, the PCD must complete the specialty referral request form. At this point, the following options are available:
 - (a) The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to Us. We will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Contracted Specialist to schedule an appointment.

(b) The PCD may determine that the direct referral to the Contracted Specialist fits the referral policy guidelines. If so, the PCD will complete the specialty referral request form and provide this form to the Member and the Contracted Specialist. We will retrospectively review the direct referral upon receipt of the Contracted Specialist's claim, once the Contracted Specialist's procedures or services have been completed.

If the PCD's request for specialty referral is denied (an Adverse Determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. Refer to the Grievance Process section for additional information.

If the service in question is a covered service and no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

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

A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

When specialty dental care is referred by the PCD, a Member will be referred to a Contracted Specialist for treatment. The Network includes Contracted Specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Policy's approved Service Area. If there is no Contracted Specialist in the Policy's approved Service Area, We will refer the Member to a Non-Contracted specialist Dentist of Our choice.

B425.0091

Option F

Facilities

MDC PCD's available under the Policy Contract are listed in the Network General Dentist booklet. MDC's PCD offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if You cannot keep Your scheduled appointment, You must notify Your PCD at least 24 hours in advance or You will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet. Broken appointment fees will be waived in exigent circumstances (e.g., emergency hospitalization of Member).

You may contact MDC's Member Services Department at 1-800-273-3330 to request the Network General Dentist booklet.

B425.1040

Option F

Telehealth

MDC shall provide coverage for health care services appropriately delivered through telehealth on the same basis and to the same extent that the Member has coverage for the same service through in-person diagnosis, consultation, or treatment.

B425.1223

Option F

Emergency Dental Services

The MDC Network also provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. You should contact Your selected PCD, who will arrange for such care. If You are not able to reach Your PCD in an emergency during normal business hours, You must call MDC's Member Services Department for instructions. If You are not able to reach Your PCD in an emergency after normal business hours, You may seek Emergency Dental Services from any Dentist. MDC will reimburse You for the cost of the Emergency Dental Services less any Patient Charge which may apply. You should present a statement from the treating Dentist. You must file a claim within 180 days of service. This should be submitted to the address listed on page 1.

B425.1224

Option F

Out-of-Area Emergency Dental Services

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

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

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

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

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

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

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

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

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

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

B425.1031

Continuity of Care - Terminated Dentist

The Member may request for the continuation of covered services to be rendered by a terminated Contracted Dentist when the Member is undergoing treatment from a terminated Dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current Members or 180 days from the effective date for newly covered Members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Contracted Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members.

This provision does not apply to Contracted Dentists who voluntarily leave the plan. The Member must make the request in writing and send to:

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. The terminating Dentist must accept the contracted rate for that Member's treatment and agree not to seek payment from the Member for any amounts for which the Member would not be responsible if the Dentist were still in the network. The approval of the request to continue Member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating Dentist or Member wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated Dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

B425.1257

Option F

Continuity of Care - Non-Contracted Dentist

The Member, including a newly covered Member, may request for the continuation of covered services to be rendered by the Non-Contracted Dentist when the Member is undergoing treatment from the Non-Contracted Dentist for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Contracted Dentist's Agreement or 12 months from the Effective Date of coverage for newly covered Members. The Member must make the request in writing and send to:

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the Member's dental records from the Member's Dentist in order to evaluate the request. The Dental Director (or his/her designee) will determine if the Member is eligible for continuation of care under this Policy and the California Knox-Keene Act.

The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by Policy; and
3. The potential clinical effect that a change of Dentist would have on the Member's treatment.

B425.1258

Option F

Extended Dental Benefits

If a Member's coverage ends, We extend dental expense benefits for him or her under this Policy. We extend benefits for covered services other than orthodontic services only if the procedures are started before the Member's coverage ends and are completed within 90 days after the date his or her coverage ends.

- Inlays, onlays, crowns and bridges are started on the date the tooth or teeth are initially prepared.
- Dentures are started on the date the impressions are taken.
- Root canals are started on the date the pulp chamber is opened.

Coverage for orthodontic services ends upon the termination of the Member's coverage under this Policy.

The extension of benefits ends 90 days after the Member's coverage ends or the date he or she becomes covered under another plan which provides coverage for similar dental procedures, whichever occurs first. But, if the plan which succeeds this Policy excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the Member's coverage ends.

We don't grant an extension if the Member voluntarily terminates his or her coverage. And what We pay is based on all the terms of this Policy.

B425.0093

COORDINATION OF BENEFITS (COB)

A Member may have dental coverage through multiple plans. When that occurs, one plan is determined to be primary while the other is deemed to be secondary.

Rules to make the primary/secondary determination are:

- The plan without a coordination provision is always primary.
- If a medical plan provides coverage for the dental service, that plan is primary. This excludes Affordable Care Act (ACA) compliant plans.
- If both plans have a COB provision, the plan providing coverage to an Employee is primary.
- A plan that provides coverage for an active Employee will be primary over a retiree plan.
- If a child is covered under both parents' plans:
 - When the parents are living together, the plan of the parent whose birthday is earlier in the year is primary.
 - When the parents are separated and not living together:
 - Any applicable court order will apply.
 - With 50/50 custody situations, the plan of the parent whose birthday is earlier in the year is primary.
 - With no court order benefits will be coordinated in the following order; (1) natural parent with custody; (2) step parent with custody; (3) natural parent without custody; and (4) step parent without custody.
- When none of these rules apply, the plan that has provided coverage the longest is primary.

When We are primary, benefits are determined as if no other plan exists.

B425.0096

Option F

Coordination with a Pre-Paid Dental Plan

A Member may also be covered under another pre-paid dental plan where they pay a fixed payment amount for each covered service. When the PCD participates under both pre-paid plans, the Member will never be responsible for more than the Patient Charge.

For Contracted Specialists' services, when this Policy is secondary, any payment made by the primary carrier is credited against the Patient Charge. In many cases the Member will have no out-of-pocket expenses.

B425.0097

Option F

Coordination with a PPO Dental Plan

When a Member is covered by this Policy and a fee-for-service plan, the following rules will apply:

- For PCD services: If this Policy is the primary plan, the PCD submits a claim to the secondary plan for the Patient Charge amount. Any payment made by the secondary carrier must be deducted from the Member's Patient Charge.
- For PCD services: If this Policy is the secondary plan, the PCD submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the Patient Charge, reducing the Member's out-of-pocket expense.
- For Contracted Specialist services: If this Policy is the primary plan, benefits are paid as usual.
- For Contracted Specialist services: If this Policy is the secondary plan, any payment made by the primary carrier is credited against the Patient Charge, reducing the Member's out-of-pocket expense.

B425.0098

Our Right to Certain Information

In order to coordinate benefits, We need certain information. A Member must supply Us with as much information as he or she can. If he or she can't give Us all the information needed, We have the right to request this information from any source. If another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information, We can't be held liable for such action except as required by law.

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

B425.0099

GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison ("QCL") who processes the grievances. The QCL can be contacted at 1-800-273-3330 or by mail to P.O. Box 25256, Lehigh Valley, PA 18002-5256. The QCL hours are from 8:00 a.m. to 5:00 p.m. Pacific Time. Grievances may also be submitted on Our website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

- Administrative Services: financial, accounting, procedural matters, coverage information such as effective dates, explanations of policy and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.
- Health Services: quality of care, access, availability, standards of care, appeal of denied second opinion requests, appeals of Specialty Referral decisions, professional and ethical considerations.

A grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding MDC's operation, including but not limited, to Policy administration, denial of access to a specialty referral as services are covered at the general Dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for the lack of medical necessity will be handled by the grievance process. Where MDC cannot distinguish between an inquiry and a grievance, it shall be considered a grievance.

A grievance and a complaint are one and the same.

Coverage dispute means that a Member is not provided a covered service as a Policy benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the customer services representative documents the call and works with the Member to resolve the issue. If the issue is as an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the customer services department. All other issues that are grievances will be documented on a grievance form by the customer services representative on behalf of the Member and the grievance form will be forwarded to the Quality of Care Liaison or Designee (QCL). The Member may be sent a grievance form to complete, if requested.

When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work with the QCL and provide accommodation, according to MDC guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by MDC. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.
3. Members may file a grievance up to 180 calendar days following any incident or action that is the subject of the dissatisfaction. In the case of a grievance alleging that the Member's coverage has been or will be improperly cancelled, rescinded, or not renewed, the 180 days begins on the date indicated on the Notice of Cancellation, Rescission, or Nonrenewal.
4. No later than five (5) calendar days after receipt of the grievance, or three (3) calendar days for grievances received via the MDC website, an acknowledgment letter is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL that a review is taking place and the grievance will be responded to within 30 days from the date of MDC's receipt of the grievance in a resolution letter.
5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the Dentist or office personnel. MDC may arrange a second opinion, if appropriate.

6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 calendar days from the date of MDC's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution.

The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his/her review of available documentation by initialing a copy of the resolution letter.

The resolution letter to the Member will detail in a clear, concise manner the reasons for MDC's response. For grievances involving the delay, denial or modification of dental care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If MDC, or one of its clinical reviewers, issues a determination delaying, denying or modifying dental care services based in whole or in part on a finding that the proposed dental care services are not a covered benefit under the Policy that applies to the Member, the letter shall clearly specify the provisions in the Policy that exclude that coverage. In the event that an MDC grievance involves the delay, modification or denial of a covered service due to medical necessity, the resolution letter will include an IMR application and a Department of Managed Health Care addressed envelope.

B425.1260

Option F

7. Within thirty (30) calendar days following receipt of a resolution letter, a Member, or Member's Designee, may also request voluntary mediation with MDC prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a Member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care. In order to initiate mediation, the Member or the Member's Designee and MDC shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

Following the use of the voluntary mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Dentist.

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

9. 9.Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) calendar days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function; for any case involving cancellation, rescission, or nonrenewal of coverage; or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.
10. MDC shall keep all copies of grievances, and the responses to grievances, for a period of five years.
11. MDC's Secretary, who is an officer of the plan, or designee, has primary responsibility for MDC's grievance system.
12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by MDC and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.
13. MDC asserts that there is no discrimination against a Member (including cancellation of the contract) solely on the grounds that the Member filed a complaint.

The Department of Managed Health Care may contact MDC's Quality Management Staff regarding urgent grievances every business day from 8:00 am to 5:00 pm by calling 1-800-273-3330. For urgent grievances received from the Department of Managed Health Care during business hours, MDC will respond within 30 minutes. For urgent grievances after business hours, The Department of Managed Health Care should contact MDC's staff in the following order:

14. Dental Director/Plan Officer Responsible for Grievances at 1-310-908-1917, Quality of Care Liaison at 1-818-437-4177, and President at 1-207-210-8727. For urgent grievance calls received after hours, the above listed personnel will respond to the Department of Managed Health Care within one (1) hour after initial contact. Within one (1) business day of receipt of the Department of Managed Health Care's notice of acceptance of a proper complaint related to the cancellation, rescission, or nonrenewal of a Member's coverage, MDC shall respond and provide the Department of Managed Health Care with a copy of all information MDC used to make its termination of coverage determination and all other relevant information necessary for the Department of Managed Health Care's review.

Grievances Requiring Expedited Review

MDC will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but are not limited to, procedures administered in a hospital, Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Policy.

MDC shall also conduct expedited review of grievances concerning the cancellation, rescission, or nonrenewal of coverage.

When MDC has notice of a grievance requiring expedited review, the grievance process requires MDC to immediately inform Members in writing of their right to notify the Department of Managed Health Care of the grievance. MDC also will provide Members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. MDC shall consider the Member's medical condition when determining the response time for an expedited grievance.

If the Member files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, MDC shall continue to provide coverage to the Member pursuant to the terms of the Member's Policy while the grievance is pending with MDC and/or the Department of Managed Health Care.

The following grievance disclosure will be on all Member correspondence:

Disclosure:

With respect to certain actions that impact You and Your coverage, Managed Dental Care or Your Employer will provide You with notice:

- When premium has not been paid and Your coverage is in force due solely to the Policy's Grace Period;
- When this Policy or Your coverage under this Policy is rescinded due to certain contractual provisions; or
- When this Policy is terminated for any other reason as may be allowed by the Policy.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance

involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhca.ca.gov** has complaint forms, IMR application forms, and instructions online.

You may also access grievance forms at Managed Dental Care's website at **www.manageddentalcare.net**. Click on the "GRIEVANCE FORM" Portal box or may be obtained by contacting MDC's Customer Care Team at (800) 273-3330.

Note: Free language assistance services are available for You and Your dependents to assist with Your dental needs. Please contact Managed Dental Care's Member Services Department at 1-800-273-3330, Your assigned network general dentist or Your network specialist (for Managed Dental Care's approved specialty care) if English is not Your or Your dependents preferred spoken or written language.

Nota: Los servicios gratuitos de ayuda con el idioma estan disponibles para usted y sus dependientes para ayudarle con sus necesidades dentales. Si el ingles no es el idioma preferido de usted o sus dependientes, por favor comuniquese a nuestro Departamento de Servicios para Miembros al 1-800-273-3330, su dentista general de red asignada o su especialista de red (para una atencisn especializada de Managed Dental Care).

B425.1226

Option F

Covered Services

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

Covered services include:

DIAGNOSTIC

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

* A complete list of covered diagnostic services is listed in the Schedule of Benefits.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed in the Schedule of Benefits.

RESTORATIVE

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

* A complete list of covered restorative services is listed in the Schedule of Benefits.

ENDODONTICS

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

* A complete list of covered endodontic services is listed in the Schedule of Benefits.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed in the Schedule of Benefits.

**PROSTHODONTICS
(Removable)**

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

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

**PROSTHODONTICS
(Fixed)**

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

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

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

ORAL SURGERY

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

* A complete list of covered oral surgery services is listed in the Schedule of Benefits.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed in the Schedule of Benefits.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed in the Schedule of Benefits.

A list of the services covered by this Policy, including Patient Charges is provided in the section Schedule of Benefits.

Exclusions and limitations will apply to some of the services. Refer to the Benefit Limitations, Additional Conditions and Exclusions sections of the Schedule of Benefits.

B425.1227

Option F

DEFINITIONS

This section defines certain terms appearing in Your Evidence of Coverage.

B425.0712

Option F

Act: This term means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

B425.0713

Option F

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B425.0102

Option F

Alternative Procedure: This term means a procedure other than that recommended by the Member's Primary Care Dentist, but which in the opinion of the Primary Care Dentist also represents an acceptable treatment approach for the Member's dental condition.

B425.0103

Option F

Code: This term means the California Health and Safety Code.

B425.0714

Option F

Combined Evidence of Coverage and Disclosure Form: This term means this booklet issued to You, which summarizes the essential terms of this Policy.

B425.0724

Option F

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Us to participate in Our dental Network.

B425.0105

Option F

Contracted General Dentist: This term means a licensed dentist under contract with Us who is listed in Our directory of Contracted Dentists as a general practice dentist and who may be selected as a Primary Care Dentist by a Member.

B425.0106

Option F

Contracted Specialist: This term means a licensed Dentist under contract with Us as an endodontist, oral surgeon, orthodontist, pediatric dentist or periodontist.

B425.0107

Option F

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or Evidence of Coverage and covered by this Policy.

B425.0715

Option F

Effective Date: This term means the date the Policy goes into force and effect as stated on the cover page of the Evidence of Coverage of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Evidence of Coverage of Coverage.

B425.0717

Option F

Eligibility Date: This term means the earliest date You are eligible for coverage under this Evidence of Coverage as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Evidence of Coverage.

B425.0719

Option F

Emergency Dental Service: This term means services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort or to prevent the imminent loss of teeth.

B425.0113

Option F

Evidence of Coverage: This term means this certificate of coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Evidence of Coverage.

B425.0720

Option F

Full-time: This term means:

You are not a Part-time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 20 hours per week) at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B425.0117

Option F

Member: This term means You, if You are covered by this Policy, and any of Your covered dependents.

B425.0118

Option F

Network: This term means The Managed Dental Care network.

B425.0120

Option F

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Us to provide dental services to Employees in Our benefit Policy.

B425.0122

Option F

Patient Charge: This term means the amount the Member is responsible for. Patient Charge amounts are listed under the Covered Dental Procedures and Patient Charges section of the Schedule of Benefits.

B425.0123

Option F

Policy: This term means the Group Dental Coverage described in the Policy and this Evidence of Coverage.

B425.0721

Option F

Policyholder: This term means an Employer that is offering benefits to a Member under this Policy.

B425.0125

Option F

Primary Care Dentist (PCD): This term means a Contracted General Dentist selected by a Member who is responsible for providing or arranging for a Member's dental services.

B425.0126

Option F

Prior Carrier's Group Dental Policy: This term means the Employer's Policy of group dental coverage which was in force immediately prior to this Policy. For a Policy to be considered a Prior Policy, the Policy with Us must start immediately after the prior coverage ends.

B425.0128

Option F

Qualifying Event: This term means a specific occurrence that changes a Member's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental Policy; divorce; death of Your Spouse; termination of another dental Policy; or any other event as required by state or federal law or in accordance with Your Employer's rules.

B425.0130

Option F

Service Area: This term means the geographic area in which We have arranged to provide for dental services for Members.

B425.0131

Option F

Sensitive Services: This term means covered services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

B425.1225

Option F

Spouse: This term means the person to whom You are legally married, or Your domestic partner, civil union partner or equivalent as recognized and allowed by federal law, state law or local law in Your state of residence or the state in which the marriage or Your domestic partner, civil union partner or equivalent was recorded.

B425.1050

Option F

We, Us, Our and MDC: These terms mean Managed Dental Care of California.

You or Your or Yourself: These terms mean the covered Employee.

B425.0723

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

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

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

ERISA provides that all plan participants shall be entitled to:

**Receive Information
About Your Plan
and Benefits**

- (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.

**Prudent Actions By
Plan Fiduciaries**

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

**Enforcement Of
Your Rights**

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order and Qualified Domestic Relations 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 dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

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

If you have questions about this section, see your plan administrator.

Statement of Erisa Rights (Cont.)

Dental Benefits
Claims Procedure Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

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

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

B425.0167

Option F

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

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

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

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

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

Adverse Benefit Determination

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

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either 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.

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. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

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

In reviewing an appeal, Guardian will:

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

- In deciding an appeal based upon a dental or 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 dental or medical 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 professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

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

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

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

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

B425.0168

Option F

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017
1-800-273-3330

GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Policy, as well as the Patient Charges, Benefit Limitations, Additional Conditions and the Exclusions. Please read the entire Certificate of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

B425.1259

Option F

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - U40 G

The procedures covered by the Policy are named in this list. If a procedure is not on this list, it is not covered. All procedures must be provided by the assigned Primary Care Dentist (PCD) or by referral to a Contracted Specialist.

A Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of the Policy, including the Benefit Limitations, Additional Conditions and Exclusions.

A Member may be charged a Patient Charge for a broken appointment if the dental office is not given at least 24 hours' notice of cancellation.

The Patient Charges listed are only valid for covered procedures that are: (1) started and completed under the Policy, and (2) rendered by Contracted Dentists.

B425.1112

Option F

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES - PLAN U40 G**

**CDT CODE Current Dental Terminology (CDT) © American Dental Association
 (ADA)**

CDT CODE	COVERED DENTAL PROCEDURES	PATIENT CHARGE
D0100 - D0999	DIAGNOSTICS	
D0999	Office visit during regular hours, general dentist only	\$0.00
D0120	Periodic oral evaluation - established patient	\$0.00
D0140	Limited oral evaluation - problem focused	\$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	\$0.00
D0150	Comprehensive oral evaluation - new or established patient	\$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	\$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	\$0.00
D0210	Intraoral - complete series (including bitewings)	\$0.00
D0220	Intraoral - periapical - first film	\$0.00
D0230	Intraoral - periapical - each additional film	\$0.00
D0240	Intraoral - occlusal film	\$0.00
D0270	Bitewing - single film	\$0.00
D0272	Bitewings - 2 films	\$0.00
D0273	Bitewings - 3 films	\$0.00
D0274	Bitewings - 4 films	\$0.00
D0277	Vertical bitewings - 7 to 8 films	\$0.00
D0330	Panoramic film	\$0.00
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	\$50.00
D0460	Pulp vitality tests	\$0.00
D0470	Diagnostic casts	\$0.00
D1000 - D1999	PREVENTIVE	
D1110	Prophylaxis - adult, for the first two services in any 12-month period	\$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period	\$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period	\$60.00
D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	\$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period	\$0.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D1206	Topical fluoride (prophylaxis not included) - child, for the first two services in any 12-month period	\$12.00
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period	\$20.00
D1310	Nutritional instruction for control of dental disease	\$0.00
D1330	Oral hygiene instructions	\$0.00
D1351	Sealant - per tooth (molars)	\$10.00
D9999	Sealant - per tooth (non-molars)	\$35.00
D1510	Space maintainer - fixed - unilateral	\$65.00
D1515	Space maintainer - fixed - bilateral	\$110.00
D1525	Space maintainer - removable - bilateral	\$110.00
D1550	Re-cementation of fixed space maintainer	\$15.00
D1555	Removal of fixed space maintainer	\$20.00
 D2000 - D2999 RESTORATIVE		
D2140	Amalgam - 1 surface, primary or permanent	\$8.00
D2150	Amalgam - 2 surfaces, primary or permanent	\$12.00
D2160	Amalgam - 3 surfaces, primary or permanent	\$14.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	\$17.00
D2330	Resin-based composite - 1 surface, anterior	\$20.00
D2331	Resin-based composite - 2 surfaces, anterior	\$25.00
D2332	Resin-based composite - 3 surfaces, anterior	\$30.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	\$45.00
D2390	Resin-based composite crown, anterior	\$50.00
D2391	Resin-based composite - 1 surface, posterior	\$35.00
D2392	Resin-based composite - 2 surfaces, posterior	\$40.00
D2393	Resin-based composite - 3 or more surfaces, posterior	\$45.00
D2394	Resin-based composite - 4 or more surfaces, posterior	\$50.00
D2510	Inlay - metallic - 1 surface	\$180.00
D2520	Inlay - metallic - 2 surfaces	\$230.00
D2530	Inlay - metallic - 3 or more surfaces	\$235.00
D2542	Onlay - metallic - 2 surfaces	\$235.00
D2543	Onlay - metallic - 3 surfaces	\$240.00
D2544	Onlay - metallic - 4 or more surfaces	\$245.00
D2610	Inlay - porcelain/ceramic - 1 surface	\$180.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	\$230.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	\$235.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	\$235.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	\$240.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	\$245.00
D2740	Crown - porcelain/ceramic substrate	\$270.00
D2750	Crown - porcelain fused to high noble metal	\$250.00
D2751	Crown - porcelain fused to predominantly base metal	\$250.00
D2752	Crown - porcelain fused to noble metal	\$250.00
D2780	Crown - 3/4 cast high noble metal	\$240.00
D2781	Crown - 3/4 cast predominantly base metal	\$240.00
D2782	Crown - 3/4 cast noble metal	\$240.00
D2783	Crown - 3/4 porcelain/ceramic	\$240.00
D2790	Crown - full cast high noble metal	\$250.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D2791	Crown - full cast predominantly base metal	\$250.00
D2792	Crown - full cast noble metal	\$250.00
D2794	Crown - titanium	\$250.00
D2910	Recement inlay, onlay, or partial coverage restoration	\$20.00
D2915	Recement cast or prefabricated post and core	\$20.00
D2920	Recement crown	\$20.00
D2930	Prefabricated stainless steel crown - primary tooth	\$60.00
D2931	Prefabricated stainless steel crown - permanent tooth	\$60.00
D2932	Prefabricated resin crown	\$90.00
D2933	Prefabricated stainless steel crown with resin window	\$90.00
D2934	Prefabricated esthetic coated stainless steel crown primary tooth	\$100.00
D2940	Sedative filling	\$15.00
D2950	Core buildup, including any pins	\$50.00
D2951	Pin retention - per tooth, in addition to restoration	\$15.00
D2952	Post & core in addition to crown, indirectly fabricated	\$95.00
D2953	Each additional indirectly fabricated post - same tooth	\$29.00
D2954	Prefabricated post and core in addition to crown	\$85.00
D2957	Each additional prefabricated post - same tooth	\$19.00
D2960	Labial veneer (resin laminate) - chairside	\$235.00
D2970	Temporary crown (fractured tooth)	\$75.00
D2971	Additional procedures to construct new crown under existing partial denture framework	\$125.00
 D3000 - D3999 ENDODONTICS		
D3110	Pulp cap - direct (excluding restoration)	\$10.00
D3120	Pulp cap - indirect (excluding restoration)	\$10.00
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	\$30.00
D3221	Pulpal debridement, primary and permanent teeth	\$30.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	\$30.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	\$37.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	\$40.00
D3310	Root canal, anterior (excluding final restoration)	\$95.00
D3320	Root canal, bicuspid (excluding final restoration)	\$160.00
D3330	Root canal, molar (excluding final restoration)	\$170.00
D3331	Treatment of root canal obstruction; non-surgical access	\$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$95.00
D3333	Internal root repair or perforation defects	\$80.00
D3346	Retreatment of previous root canal therapy - anterior	\$310.00
D3347	Retreatment of previous root canal therapy - bicuspid	\$370.00
D3348	Retreatment of previous root canal therapy - molar	\$445.00
D3410	Apicoectomy/periradicular surgery - anterior	\$135.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	\$145.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	\$155.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D3426	Apicoectomy/periradicular surgery (each additional root)	\$80.00
D3430	Retrograde filling - per root	\$35.00
D3950	Canal preparation and fitting of preformed dowel or post	\$20.00
 D4000 - D4999 PERIODONTICS		
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$80.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$45.00
D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$190.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$114.00
D4249	Clinical crown lengthening - hard tissue	\$170.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	\$255.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	\$155.00
D4268	Surgical revision procedure, per tooth	\$0.00
D4270	Pedicle soft tissue graft procedure	\$185.00
D4271	Free soft tissue graft procedure (including donor site surgery)	\$205.00
D4273	Subepithelial connective tissue graft procedures, per tooth	\$225.00
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	\$30.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	\$18.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$35.00
D4910	Periodontal maintenance, for the first two services in any 12-month period	\$30.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	\$25.00
D4999	Periodontal maintenance, for each additional service in same 12-month period	\$60.00
 D5000 - D5999 PROSTHODONTICS - REMOVABLE		
D5110	Complete denture - maxillary	\$345.00
D5120	Complete denture - mandibular	\$345.00
D5130	Immediate denture - maxillary	\$345.00
D5140	Immediate denture - mandibular	\$345.00
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	\$310.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	\$310.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$355.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	\$355.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	\$430.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	\$430.00
D5410	Adjust complete denture - maxillary	\$20.00
D5411	Adjust complete denture - mandibular	\$20.00
D5421	Adjust partial denture - maxillary	\$20.00
D5422	Adjust partial denture - mandibular	\$20.00
D5510	Repair broken complete denture base	\$45.00
D5520	Replace missing or broken teeth - complete denture (each tooth) . . .	\$35.00
D5610	Repair resin denture base	\$45.00
D5620	Repair cast framework	\$80.00
D5630	Repair or replace broken clasp	\$60.00
D5640	Replace broken teeth - per tooth	\$35.00
D5650	Add tooth to existing partial denture	\$45.00
D5660	Add clasp to existing partial denture	\$45.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	\$160.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	\$160.00
D5710	Rebase complete maxillary denture	\$125.00
D5711	Rebase complete mandibular denture	\$125.00
D5720	Rebase maxillary partial denture	\$125.00
D5721	Rebase mandibular partial denture	\$125.00
D5730	Reline complete maxillary denture (chairside)	\$65.00
D5731	Reline complete mandibular denture (chairside)	\$65.00
D5740	Reline maxillary partial denture (chairside)	\$65.00
D5741	Reline mandibular partial denture (chairside)	\$65.00
D5750	Reline complete maxillary denture (laboratory)	\$120.00
D5751	Reline complete mandibular denture (laboratory)	\$120.00
D5760	Reline maxillary partial denture (laboratory)	\$120.00
D5761	Reline mandibular partial denture (laboratory)	\$120.00
D5820	Interim partial denture (maxillary)	\$95.00
D5821	Interim partial denture (mandibular)	\$95.00
D5850	Tissue conditioning, maxillary	\$30.00
D5851	Tissue conditioning, mandibular	\$30.00

D6200 - D6999 PROSTHODONTICS - FIXED

D6210	Pontic - cast high noble metal	\$230.00
D6211	Pontic - cast predominantly base metal	\$230.00
D6212	Pontic - cast noble metal	\$230.00
D6214	Pontic - titanium	\$230.00
D6240	Pontic - porcelain fused to high noble metal	\$230.00
D6241	Pontic - porcelain fused to predominantly base metal	\$230.00
D6242	Pontic - porcelain fused to noble metal	\$230.00
D6245	Pontic - porcelain/ceramic	\$240.00
D6600	Inlay - porcelain/ceramic, - 2 surface	\$230.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	\$235.00
D6602	Inlay - cast high noble metal, - 2 surfaces	\$230.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces	\$235.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D6604	Inlay - cast predominantly base metal, - 2 surfaces	\$230.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	\$235.00
D6606	Inlay - cast noble metal, 2 surfaces	\$230.00
D6607	Inlay - cast noble metal, 3 or more surfaces	\$235.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	\$235.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	\$240.00
D6610	Onlay - cast high noble metal, 2 surfaces	\$235.00
D6611	Onlay - cast high noble metal, 3 or more surfaces	\$240.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	\$235.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	\$240.00
D6614	Onlay - cast noble metal, 2 surfaces	\$235.00
D6615	Onlay - cast noble metal, 3 or more surfaces	\$240.00
D6624	Inlay - titanium	\$230.00
D6634	Onlay - titanium	\$235.00
D6740	Crown - porcelain/ceramic	\$270.00
D6750	Crown - porcelain fused to high noble metal	\$250.00
D6751	Crown - porcelain fused to predominantly base metal	\$250.00
D6752	Crown - porcelain fused to noble metal	\$250.00
D6780	Crown - 3/4 cast high noble metal	\$240.00
D6781	Crown - 3/4 cast predominantly base metal	\$240.00
D6782	Crown - 3/4 cast noble metal	\$240.00
D6783	Crown - 3/4 porcelain/ceramic	\$240.00
D6790	Crown - full cast high noble metal	\$250.00
D6791	Crown - full cast predominantly base metal	\$250.00
D6792	Crown - full cast noble metal	\$250.00
D6794	Crown - titanium	\$250.00
D6930	Recement fixed partial denture	\$15.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	\$95.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$85.00
D6973	Core buildup for retainer, including any pins	\$55.00
D6976	Each additional cast post - same tooth	\$29.00
D6977	Each additional prefabricated post - same tooth	\$19.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment	\$125.00
 D7000 - D7999 ORAL AND MAXILLOFACIAL SURGERY		
D7111	Extraction, coronal remnants - deciduous tooth	\$10.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	\$10.00
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	\$30.00
D7220	Removal of impacted tooth - soft tissue	\$50.00
D7230	Removal of impacted tooth - partially bony	\$70.00
D7240	Removal of impacted tooth - completely bony	\$80.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	\$90.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$35.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D7261	Primary closure of a sinus perforation	\$250.00
D7280	Surgical access of an unerupted tooth	\$130.00
D7283	Placement of device to facilitate eruption of impacted tooth	\$40.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	\$70.00
D7286	Biopsy of oral tissue - soft	\$65.00
D7288	Brush biopsy - transepithelial sample collection	\$65.00
D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	\$50.00
D7311	Alveoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	\$25.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	\$70.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	\$49.00
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	\$85.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	\$160.00
D7471	Removal of lateral exostosis (maxilla or mandible)	\$125.00
D7472	Removal of torus palatinus	\$125.00
D7473	Removal of torus mandibularis	\$125.00
D7510	Incision and drainage of abscess - intraoral soft tissue	\$40.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	\$44.00
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	\$95.00
D7963	Frenuloplasty	\$152.00
 D8000 - D8999 ORTHODONTICS		
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition	\$1500.00
D8090	Comprehensive orthodontic treatment of the adult dentition	\$2800.00
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	\$250.00
D8670	Periodic orthodontic treatment visit	\$0.00
D8680	Orthodontic retention	\$400.00
 D9000 - D9999 ADJUNCTIVE GENERAL SERVICES		
D9110	Palliative (emergency) treatment of dental pain - minor procedure . . .	\$15.00
D9120	Fixed partial denture sectioning	\$10.00
D9215	Local anesthesia	\$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes	\$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes	\$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes	\$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes	\$75.00

**COVERED DENTAL PROCEDURES AND PATIENT
CHARGES PLAN U40 G (Cont.)**

D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	\$30.00
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	\$0.00
D9440	Office visit - after regularly scheduled hours	\$50.00
D9450	Case presentation, detailed and extensive treatment planning	\$0.00
D9951	Occlusal adjustment - limited	\$20.00
D9971	Odontoplasty, 1-2 teeth	\$20.00
D9972	External bleaching - per arch	\$165.00
	Broken Appointment	\$25.00

Option F

PLAN U40 G

B425.1086

Option F

BENEFIT LIMITATIONS

This section lists the dental benefits and procedures Members are allowed to obtain through the Policy when the procedures are necessary for their dental health, consistent with professionally recognized standards of practice, subject to the Benefit Limitations, Additional Conditions and Exclusions listed below.

NOTICE: Any benefit that includes an age restricted limitation will be subject to an exception based on medical necessity.

B425.1017

Option F

- General**
- Emergency Dental Services when more than fifty (50) miles from the PCD office: Limited to a \$50.00 reimbursement per incident.
 - Emergency Dental Services when provided by a Dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us: Limited to the benefit for palliative treatment (D9110) only.

B425.0142

Option F

- Diagnostic**
- One intraoral complete series of radiographic images and one panoramic radiographic image: Limited to 1 each in 36 months.
 - Bitewing radiographic images: Limited to 2 sets in 12 months.
 - Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Limited to 1 in 24 months for persons age 40 or older.

B425.1088

Option F

- Preventive**
- Prophylaxis (D1110 or D1120) or periodontal maintenance (D4910): Limited to 2 in 12 months. One of the covered periodontal maintenance may be performed by a periodontist Contracted Specialist if done within 3 to 6 months following completion of approved periodontal scaling and root planing or osseous surgery by a periodontist Contracted Specialist. Members are eligible to receive 2 additional prophylaxes or periodontal maintenance in the same 12 months at the Patient Charge of D1999 (for prophylaxes) or D4999 (for periodontal maintenance).
 - Fluoride treatment: Limited to 2 in 12 months. Members are eligible to receive 2 additional fluoride treatments in the same 12 months at the Patient Charge of D2999.
 - Sealants or preventive resin restoration: Limited to permanent teeth, up to age 16, once per tooth in 36 months.

B425.1089

Option F

- Crowns & Fixed Partial Dentures (Bridges)**
- Crowns, fixed partial dentures (bridges), inlays, onlays & veneers: Covered when recommended by the PCD. The replacement of a crown, fixed partial denture (bridge), inlay, onlay or veneer is limited to once in 5 years based on the original placement date while covered under the Policy.
 - Multiple crown and fixed partial denture (bridge) unit treatment plan: When a Member's treatment plan includes 6 or more covered units of crown and/or fixed partial denture (bridge) to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or fixed partial denture (bridge), plus an additional charge per unit (D6999), as shown in the Covered Dental Procedures and Patient Charges section.
 - Porcelain crowns and/or porcelain fused to metal crowns: Covered on anterior, bicuspid and molar teeth when recommended by the PCD.
 - The Policy provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.

B425.1090

Option F

- Periodontics**
- Gingival flap procedure or osseous surgery: Limited to 1 procedure per quadrant in 36 months.
 - Tissue grafts: Limited to 1 procedure per tooth/site in 36 months.
 - Periodontal scaling and root planing: Limited to once per quadrant in 12 months.

B425.1091

Option F

- Prosthodontics**
- Reline and rebase of a complete or partial denture: Limited to once per denture in 12 months.
 - The benefit for dentures includes all post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures includes follow-up care for 6 months but does not include rebasing or relining procedures or a complete new denture.
 - Replacement of dentures: Covered when recommended by the PCD and only if the existing denture cannot be made satisfactory by reline, rebase or repair. The replacement of a denture is limited to once in 5 years based on the original placement date while covered under the Policy.
 - Immediate dentures are not subject to the 5-year replacement limitation.

B425.0152

Option F

- Oral and Maxillofacial Surgery**
- Routine post-operative office visits and care: Included in the surgical procedure.

B425.0154

Option F

- Orthodontics**
- The Policy covers orthodontic procedures as listed under Covered Dental Procedures and Patient Charges. Coverage is limited to one course of comprehensive treatment per Member. Treatment must be preauthorized and be performed by an orthodontist Contracted Specialist.
 - The listed Patient Charge for each phase of comprehensive orthodontic treatment covers up to 24 months of active treatment. If treatment is necessary beyond 24 months, the Member will be responsible for each additional month of treatment, based upon the orthodontist Contracted Specialist's contract.
 - Orthodontic procedures are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Policy except as described under the Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.

- If a Member's coverage terminates after the fixed banding appliances are inserted, the Member is responsible for any additional charges incurred for the remaining orthodontic treatment. The orthodontist Contracted Specialist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the orthodontist Contracted Specialist for procedures after the termination date.
- Retention procedures are covered at the Patient Charge shown in the Covered Dental Procedures and Patient Charges section. They are covered only if following a course of comprehensive orthodontic treatment started and completed under the Policy.
- If a Member transfers to another orthodontist Contracted Specialist after authorized comprehensive orthodontic treatment has started under the Policy, the Member will be responsible for any additional costs associated with the change in orthodontist Contracted Specialist and subsequent treatment.
- The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility.
- The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention procedures are covered only following a course of comprehensive orthodontic treatment covered under the Policy.
- The Policy does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the Member's responsibility.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Policy provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the orthodontist Contracted Specialist's usual fee.

B425.1092

Option F

Adjunctive General Services

- Deep sedation/general anesthesia and IV sedation: Limited to procedures provided by an oral surgeon Contracted Specialist. Not all oral surgeon Contracted Specialists offer these procedures. The Member is responsible for identifying and receiving procedures from an oral surgeon Contracted Specialist who is willing to provide deep sedation/general anesthesia or IV sedation. The Member's Patient Charge is shown in the Covered Dental Procedures and Patient Charges section.

B425.1093

Option F

ADDITIONAL CONDITIONS

B425.0157

Option F

Alternative Procedure Policy There may be a number of accepted methods of treating a specific dental condition. In all cases where there is more than one course of treatment (procedure) available, a full disclosure of all the treatment options must be given to the Member before treatment is initiated. This PCD-presented document should include a written treatment plan, as well as the cost of each treatment option, in order to minimize the potential for confusion over what the Member should pay, and to fully document the informed consent of the treatment recommended.

When a Member selects an Alternative Procedure over the procedure recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended procedure and the Alternative Procedure chosen by the Member. The Member will also have to pay the applicable Patient Charge for the recommended procedure.

If any of the Alternative Procedures that are selected by the Member are not covered under the Policy, the Member must pay the PCD's usual fee for the Alternative Procedure.

If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not an appropriate procedure for the condition being treated), the PCD is not obliged to provide that treatment even if it is a covered procedure under the Policy.

Members can request and receive a second opinion by contacting Our Member Services department in the event they have questions regarding the recommendations of the PCD or Contracted Specialist.

B425.0158

Option F

Exceptions to Alternative Procedure Policy When the Member selects a posterior composite restoration as an Alternative Procedure to a recommended amalgam restoration, the Alternative Procedure policy does not apply.

When the Member selects an extraction, the Alternative Procedure policy does not apply.

When the PCD recommends a crown, the Alternative Procedure policy does not apply regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The Member must pay the applicable Patient Charge for the crown actually placed.

B425.0159

Option F

Second Opinion Consultation A Member may wish to consult another Dentist for a second opinion regarding procedures recommended or performed by the Member's PCD or Contracted Specialist through a referral. To have a second opinion consultation covered by Us, the Member must call or write Our Member Services department for prior authorization. We only cover a second opinion consultation when the recommended procedures are covered under the Policy.

A Member Services associate will help identify a Contracted Specialist to perform the second opinion consultation. The second opinion consultation will include the applicable Patient Charge for code D9310.

The Plan's benefit for a second opinion consultation is limited to \$50.00. If a Contracted Specialist is the consulting Dentist, the Member is responsible for the applicable Patient Charge for code D9310. If a Non-Contracted Dentist is the consulting Dentist, the Member must pay the applicable Patient Charge for code D9310 and any portion of the Dentist's fee over \$50.00.

The Member Services associate will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting Dentist.

B425.0727

Option F

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

- Restorative Treatment: Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Policy, have a patient charge equal to 85% of the Contracted General Dentist's usual fee. (There is no additional charge for high noble metal.)
- Endodontic Treatment: Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are shown in the Covered Dental Services and Patient Charges section that were started but not completed prior to the Member's eligibility to receive benefits under this Policy may be covered if the Member identifies a Contracted General Dentist or Contracted Specialist who is willing to complete the procedure at a patient charge equal to 85% of Contracted Dentist's usual fee.
- Orthodontic Treatment: Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the Member's eligibility to receive benefits under this Policy may be covered if the Member identifies a Contracted Specialist who is willing to complete the treatment at a Patient Charge equal to 85% of the Contracted Specialist's usual fee. In this situation, the Patient Charge for retention services would also be equal to 85% of the Contracted Specialist's usual fee. When comprehensive orthodontic treatment is started prior to the Member's eligibility to receive benefits under this Policy, the Patient Charge for orthodontic retention is equal to 85% of the Contracted Specialist's usual fee.

B425.1094

Option F

Treatment in Progress-Takeover Benefit for Orthodontic Treatment Provision

This provision provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another Dental HMO plan with the current/original treating orthodontist, after the Policy becomes effective. A Member may be eligible for this provision if all of these conditions are met:

- The Member was covered by another dental HMO plan just prior to the Effective Date of the Policy and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior Dental Policy.
- This benefit applies to Members of new Policies only. It does not apply to Members of existing Policies and it does not apply to persons who become newly eligible under the Group after the Effective Date of this Policy.
- The Member has such orthodontic treatment in progress at the time the Policy becomes effective.
- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- The Member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental HMO plan.
- We will only cover up to a total of 24 months of comprehensive orthodontic treatment.
- A "Treatment in Progress - Takeover Benefit for Orthodontic Treatment" form, completed in its entirety by the treating orthodontist, is submitted to Us within 6 months of the Effective Date of the Policy.

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

We will determine the Member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The Member will be paid quarterly until the benefit has been paid or until the Member completes treatment, whichever comes first. The benefit will cease if the Member's coverage under this Policy is terminated.

The benefit will not apply if the comprehensive orthodontic treatment started when the Member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the Member transfers to another orthodontist. The benefit does not apply to any other orthodontic services.

B425.1096

Option F

EXCLUSIONS

- We will not pay benefits for:**
- Treatment needed due to an on-the-job or job-related injury or a condition for which benefits are payable by Worker's Compensation, occupational disease law or similar laws, whether or not the Member claims his or her rights to such benefits.
 - Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
 - Any histopathological examination or other laboratory charges.
 - Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
 - Any oral surgery requiring the setting of a fracture or dislocation.
 - Placement of osseous (bone) grafts.
 - Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
 - Any treatments or appliances requested, recommended or performed: (a) which in the opinion of the Contracted Specialist or Contracted General Dentist are not necessary for maintaining or improving the Member's dental health, or (b) which are solely for cosmetic purposes, except for bleaching.
 - Precision attachments, stress breakers, magnetic retention or overdenture attachments.
 - The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to nitrous oxide.
 - Any procedure or treatment method which does not meet professionally recognized standards of dental practice or is considered by the American Dental Association (ADA) to be experimental in nature.
 - Replacement of lost, missing, or stolen appliances or prosthesis, or the fabrication of a spare appliance or prosthesis.
 - Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
 - Any Member request for specialist procedures or treatment which can be routinely provided by the PCD, or by a specialist without a direct referral from the PCD or a pre-authorization by Us.
 - Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits for such treatment.

- Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; (4) splint or stabilize teeth for periodontal reasons; or (5) improve cosmetic appearance, except for bleaching.
- Any procedure, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- Dental procedures, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's selected and assigned PCD, unless previous written authorization was provided by Us.
- 2D cephalometric radiographic images except when performed as part of an orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Treatment which requires the procedures of a prosthodontist.
- Treatment or Procedures which requires the services of a pediatric dentist Contracted Specialist, after the Member's 8th (eighth) birthday.
- Consultations for non-covered procedures.
- Any procedure or treatment not specifically listed in the Covered Dental Procedures and Patient Charges section.
- Any procedure associated with the placement or removal, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered procedures as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's eligibility to receive benefits under this Policy, except as described under Treatment in Progress Restorative Treatment. Inlays, onlays, crowns or fixed bridges are (a) considered to be started when the tooth or teeth are prepared; and (b) completed when the final restoration is permanently cemented. Dentures are considered to be (a) started when the impressions are taken; and (b) completed when the denture is delivered to the Member.
- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this Policy, except as described under Treatment in Progress - Endodontic Treatment. Root canal treatment is considered to be (a) started when the pulp chamber is opened; and (b) completed when the permanent root canal filling material is placed.
- Inlay, onlays, crowns, fixed bridges or dentures started by a Non-Contracted Dentist. Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. This exclusion will not apply to services that are started and which were covered under the Policy as Emergency Dental Services.

- Root canal treatment started by a Non-Contracted Dentist. Root canal treatment is considered to be started when the pulp chamber is opened. This exclusion will not apply to services that were started and which were covered under the Policy as Emergency Dental Services.
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under comprehensive orthodontic treatment or to correct or control harmful habits.
- Any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances lost or damaged.

B425.1098

COMBINED EVIDENCE OF COVERAGE AMENDMENT

This Rider amends the Combined Evidence of Coverage as follows and is effective on 07/01/2017.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

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

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

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

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

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

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

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

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

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

Managed Dental Care of California



Jill M. Purcell, President



Thomas S. Barnes, Controller

B425.0840

Option F

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN U40	Deductibles	Lifetime Maximums	Professional Services			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Bitewings Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			No Charge	Prophylaxis - \$0 - \$60; Flouride - \$0 - \$20; Sealants - \$10 - \$35; Space Maintainers - \$65 - \$110	Amalgam - \$8 - \$17; Resin - \$20 - \$50; Crowns - \$240 - \$270; Inlays & Onlays - \$180 - \$245; Labial Veneer - \$235; Miscellaneous Restorative Services - \$15 - \$125	Pulp Cap - \$10; Pulpotomy - \$30 - \$40; Root Canals - \$95 - \$170; Retreatments - \$310 - \$445; Apicoectomy - First Root - \$135 - \$155; Each Additional Root - \$80; Retrograde Filling - Per Root - \$35; Canal Preparation - \$20

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U40 (Cont.)	Deductibles	Lifetime Maximums	Professional Services (Continued)			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Compre- hensive Orthodontic Treatment Per Member	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, Up To 16th Birthday, One Per Tooth In Any 3-Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

MDC U40 0308

B850.1056

Option F

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U40 (Continued)	Professional Services (Continued)				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Services (Continued)	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Crown Lengthening; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor Excision Of Bone Tissue	Comprehensive Treatment; Retention; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia General Anesthesia Intravenous Conscious Sedation/ Analgesia
Patient Charge Range (Continued)	Gingivectomy/ Gingivoplasty - \$45 - \$80; Gingival Flap Procedure - \$114 - \$190; Osseous Surgery - \$155 - \$255; Scaling & Root Planing - \$18 - \$30; Soft Tissue Graft - \$185 - \$225; Crown Lengthening - \$170; Miscellaneous Periodontal Services - \$25 - \$30	Complete Denture - \$345; Immediate Denture - \$345; Rebase - \$125; Interim Partial - \$95; Partial Denture - \$310 - \$430; Reline - \$65 - \$120; Repair - \$35 - \$160; Tissue Conditioning - \$30; Denture Adjustment - \$20	Extractions - Coronal Total/ Remnants/ Erupted Exposed Root - \$10; Surgical Removal - \$30; Removal Of Impacted Tooth - \$50 - \$90; Alveoloplasty - \$25 - \$70; Removal of Cyst/ Tumor - \$85 - \$160; Excision Of Bone Tissue - \$125; Surgical Incision - \$40 - \$44; Other Surgical Procedures - \$40 - \$130; Other Repair Procedures - \$95 - \$152;	To Age 18 - \$1500; Over Age 18 - \$2800; Retention - \$400; Treatment Plan And Records - \$250.00	Office Visit - \$0 - \$10; After Hours Office Visit - \$50; Palliative Treatment - \$15; Local Anesthesia - \$0; General Anesthesia/ Conscious Sedation - \$75 - \$95; External Bleaching - \$165; Miscellaneous Services - \$0 - \$34

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U40 (Continued)	Professional Services (Continued)				
	Periodontic	Prosthodontics	Oral Surgery	Orthodontic	Adjunctive General Services
Limitations (Continued)	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/ Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

B850.1060

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDC U40 0308

B850.1058

Option F

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

U40 (Cont.)	Outpatient Services	Hospitalization Service	Emergency Health Coverage		Ambulance Services	Prescription Drug Services
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to \$50 Reimbursement Per Incident	Not Covered*	Not Covered*
U40 (Cont.)	Durable Medical Equipment	Mental Health Services	Chemical Dependency Services	Home Health Services	Other	
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*	

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

THIS IS A REVISED UNIFORM MATRIX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

MDC U40 0308

B850.1059

Option E

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

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

The Group Dental Insurance Coverage described in this Certificate is attached to the group Policy effective December 1, 2016. This Certificate replaces any Certificate previously issued under this Policy or under any other plan providing similar or identical benefits issued to the Policyholder by Guardian.

GROUP DENTAL INSURANCE COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is eligible for the coverage, and in the amount, described herein. In order to be eligible for coverage, the Employee must: (a) satisfy all of this Policy's eligibility and Effective Date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under the Policy; (c) all required premium payments must have been made by or on behalf of the Employee; and (d) satisfy any necessary Proof of Insurability requirements.

The Employee is not covered by any part of the Policy for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA: EXTENDED CARE HOSPITAL OF WESTMINSTER

Group Policy Number: 00531743

Effective Date: December 1, 2016

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B400.0014

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Option E

NOTICE: WE WILL PROVIDE WRITTEN NOTIFICATION BY MAIL TO THE LAST KNOWN ADDRESS OF ALL AFFECTED NONEMPLOYEE CERTIFICATE HOLDERS AT LEAST 60 DAYS PRIOR TO THE EFFECTIVE DATE OF THE FOLLOWING: TERMINATION OF THE PLAN, INCREASE IN PREMIUM, REDUCTION OR ELIMINATION OF BENEFITS OR RESTRICTION OF ELIGIBILITY NOT REQUESTED BY THE PLANHOLDER.

SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS INSURANCE, YOU MAY CONTACT THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA AS SHOWN BELOW.

www.GuardianAnytime.com

**CUSTOMER SERVICES
THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA
10 Hudson Yards
CUSTOMER SERVICES, H-6-D
NEW YORK, NY 10001**

CUSTOMER RESPONSE UNIT: 1-800-541-7846

COMPLAINT NOTICE

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

**Dental Claims Services, Quality And Compliance
The Guardian Life Insurance Company Of America
PO Box 2457
Spokane WA 99210-2457
Phone: 800-541-7846
Fax: 509-468-4590**

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

**Department Of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1 (800) 927-HELP (4357)
TDD: 1 (800) 482-4TDD (4833)
Website: www.insurance.ca.gov/01-consumers/**

B401.1932

GENERAL PROVISIONS

Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. You will only be covered for benefits if:

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

Limitation of Authority

Only the President, a Vice President or a Secretary of Guardian, has the authority to act for Us in a written and signed statement to:

- Determine whether any contract, Policy or Certificate is to be issued;
- Waive or alter any contract or Policy provisions, or any of Our requirements;
- Bind Us by any statement or promise relating to any contract issued or to be issued; or
- Accept any information or representation which is not in a signed application.

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

Incontestability

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

In the event Your insurance is rescinded, We will refund premiums paid for the periods such insurance is void.

B400.0016

Option E

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL INSURANCE COVERAGE

B400.0018

Option E

Employee Eligibility

You are eligible for Dental coverage if You are:

- In an eligible class of Employees;
- An active Full-Time Employee; and
- Working at least the minimum required number of hours in Your eligible class at:
 - The Employer's place of business;
 - Some place where the Employer's business requires You to travel; or
 - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for Dental coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Certificate.

B400.0029

Option E

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
 - A newborn child, natural child, stepchild or a child placed with you for adoption or foster care who is under age 26; and
 - A child who is incapable of self-support because of a physically or mentally disabling injury, illness or condition. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:

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

Eligible dependent does not include anyone who is insured under this Policy as the Employee.

B400.3336

Option E

Eligibility Waiting Period

You and Your dependents are eligible under this Certificate after You complete the eligibility waiting period, if any, established by the Employer.

B400.0087

Option E

When Coverage Starts

Your Employer will inform You of Your Effective Date under the Dental Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Dental Policy as stated in the Conditions Of Eligibility for Group Dental Insurance section; and
- You and Your eligible dependents have enrolled in the Dental Policy; and
- Required premiums have been paid.

You or Your eligible dependents may be considered a Late Entrant if You fail to enroll within 31 days of the Eligibility Date or a Qualifying Event. Late Entrant penalties may be imposed. Please refer to Your Schedule of Benefits.

B400.0091

Option E

Exception to When Coverage Starts

Sometimes a scheduled Eligibility Date is not a regularly scheduled work day. If the scheduled Eligibility Date falls on:

- A holiday;
- A vacation day;
- A non-scheduled work day;

and if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and
- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day.

Your coverage will start on the scheduled Eligibility Date. However, any coverage or part of coverage for which You must elect and pay all or part of the cost, will not start if You are on an approved leave and such coverage or part of coverage was not previously in force for You under a prior plan which this Certificate replaced.

B400.0094

Option E

When Your Coverage Ends

Your coverage will end on the first of the following events:

- The last day of the month in which Your Active Full-Time Work ends for any reason, except as shown below under Continuation of Coverage.
- The last day of the month in which You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for or by You.
- The date You die.

B400.0109

Option E

When Your Dependent Coverage Ends

Your dependent coverage will end on the first of the following events:

- When Your coverage ends.
- When You stop being an eligible Employee under this Certificate.
- The date the group Certificate ends, or dependent coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B400.0115

Option E

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Certificate carefully for details and discuss with Your Employer or administrator.

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

COBRA Continuation Rights

If dental insurance for You or Your dependents ends, You or Your dependents may qualify for continuation of such insurance under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA). For more information, You may contact Your Employer or visit our website at www.guardianlife.com.

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of insurance under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B400.0120

Option E

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B400.0133

Option E

DENTAL CLAIM PROVISIONS

You may visit any Dentist. After Guardian pays its portion of the Covered Charges, You are responsible for the rest. This includes any Deductible, Copayment, Coinsurance and amounts above any coverage maximum, as well as, any remaining charges up to the Dentist's total charge for services received.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on a percentile of the prevailing fee data for the Dentist's zip code. Please refer to Your Schedule of Benefits.

B400.0177

Option E

Filing A Claim

Most Dentists file claims electronically or have claim forms on hand. If they don't, You may obtain one by visiting our website at www.guardianlife.com or You may call our customer service department at (800) 541-7846 or the toll-free number listed on Your ID card. We will furnish You a claim form within 15 days of Your request.

If You have services performed by a Guardian Contracted Dentist, Your claim will be submitted for You and the payment will be sent directly to Your Dentist.

If You have services performed by a Non-Contracted Dentist, You may need to submit Your own claim. Just follow these easy steps to ensure efficient processing:

- Complete Your portion of the claim form and present the form to the Dentist for completion.
- Mail Your completed claim form to the address shown on the Guardian claim form or You can obtain our address on the Guardian website at www.guardianlife.com.

You must submit all claims for dental benefits within 12 months of the date of service.

We may require additional information to pay Your claim. This may consist of radiographic images, periodontal charting, narratives and other diagnostic materials that may support Your claim.

B400.0181

Option E

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 You have 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.

B400.3339

Option E

Appeal of Adverse Benefit Determinations

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

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

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

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

- A review that takes into account all comments, documents, records and other information submitted by You 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 You 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 You 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 You of its decision not later than 60 days after receipt of the request for review of the adverse determination.

External Reviews And Independent Medical Reviews

In the event that You believe a claim was improperly denied, modified or delayed by Guardian or one of Our providers due to the proposed health care services being not medically necessary, You have the right to request an Independent Medical Review (IMR) by the California Department of Insurance (CDI). You must request an external review within 60 days receipt of the adverse benefit determination notice.

With regard to experimental or investigative therapies, We will notify You of the right to request an IMR within 5 business days of the adverse benefit determination notice. If Your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, You can request an expedited review and the analyses and recommendations of the panel of experts will be rendered within seven days of the request for expedited review. At the request of the expert(s), the deadline can be extended by up to three days. The IMR for experimental and investigative therapies will follow the standard procedures except that the reviewer will base his or her determination on relevant medical and scientific evidence.

You can request an IMR by following the steps outlined below.

1. Notify the CDI to request an IMR by filling out an application.
2. Agree and provide written consent to participate in an IMR.
3. The CDI will determine if the request is eligible for an IMR.
4. The IMR Organization will have 30 days to review once all information is gathered unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to You, Guardian and the Insurance Commissioner.
6. The Commissioner will adopt the recommendation of the IMR organization and promptly notify You and Guardian. The decision is binding to Guardian.

B400.3340

Option E

Coordination Of Benefits (COB)

A Covered Person may have dental insurance through multiple plans. When that occurs one plan is determined to be primary while the other is deemed to be secondary.

The rules establishing the order of benefit determination are:

- (1) The benefits of a Plan which covers the person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent.

(2) Except for cases of a person for whom claim is made as a dependent child whose parents are separated or divorced, the benefits of a plan which covers the person on whose expenses claim is based as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, shall be determined before the benefits of a Plan which covers such person as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year. If either Plan does not have the provisions of this paragraph regarding dependents, which results either in each Plan determining its benefits before the other or in each Plan determining its benefits after the other, the provisions of this paragraph shall not apply, and the rule set forth in the Plan which does not have the provisions of this paragraph shall determine the order of benefits.

(3) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

(4) In the case of a person for whom claim is made as a dependent child whose parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a dependent of the stepparent, and the benefits of a Plan which covers that child as a dependent of the stepparent will be determined before the benefits of a Plan which covers that child as a dependent of the parent without custody.

(5) In the case of a person for whom claim is made as a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding paragraphs (3) and (4) above, the benefits of a Plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other Plan which covers the child as a dependent child.

When Guardian is secondary, benefits are determined so that the total payable by both plans does not exceed the allowable amount, (described below):

- If both plans are subject to a contracted fee schedule, the higher fee schedule is the allowable amount.
- If only one plan is subject to a contracted fee schedule:
 - When the primary plan is not subject to a fee schedule, Guardian's fee schedule is the allowable amount.
 - When the primary plan is subject to a fee schedule, the primary plan's fee schedule is the allowable amount.

- If neither plan is subject to a contracted fee schedule, the maximum allowed amount of either plan is the allowable amount.

In no instance will Guardian pay more as the secondary plan than it would have paid being the primary plan.

B400.3341

Option E

DENTALGUARD PREFERRED - THIS PLAN'S PREFERRED PROVIDER ORGANIZATION (PPO) INSURANCE

This Policy's benefits are paid the same for Covered Charges furnished by Contracted Dentists and Non-Contracted Dentists, however, a Covered Person will usually be left with less out-of-pocket expense when a Contracted Dentist is used.

Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers as shown below. These tiers represent specific benefit levels as described in Your Schedule of Benefits. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.

- DentalGuard Preferred Gold
- DentalGuard Preferred Silver

B400.0280

Option E

Contracted Dentists

Dentists who are contracted with Guardian's DentalGuard Preferred Provider Organization have agreed to accept a discount for the Covered Services they perform. When You visit one of these Dentists, the discount will lower Your out-of-pocket costs.

When receiving services from a Contracted Dentist, You will be responsible for any Deductible, Copayment, Coinsurance amounts above the Benefit Year Maximum and for any non-covered services. In some instances, You may be responsible for the difference between the Dentist's discounted fee and the plan allowance. For Covered Services, You will not be responsible for amounts above the Dentist's discounted fee.

Some states allow Contracted Dentists to accept discounts only on services that are covered by the Policy. Prior to Your anticipated dental services being performed, ask Your Dentist for a treatment plan that includes services to be provided with an estimated cost. (Please see Pre-Treatment Review section). If You would like more information, You may call our customer service department at (800) 541-7846 or the toll-free number listed on Your ID card.

You will need to verify if Your Dentist is contracted within Guardian's Dental Preferred Provider Organization at the time of service.

Please refer to Guardian's on-line provider directory at www.guardianlife.com.

If Your Policy provides orthodontics, the negotiated discounted fee for orthodontics does not include:

- Any incremental charges for optional orthodontic Appliances.

- Replacement or repair due to neglect of the patient.
- Treatment plans that began prior to the Eligibility Date.

B400.0189

Option E

Non-Contracted Dentists

You may visit any Dentist. After Guardian pays its portion of Covered Charges, You are responsible for the rest. This includes Your Deductible, Copayment, Coinsurance and amounts above the Benefit Year Maximum, as well as, any remaining charges up to the Dentist's total charge for services received.

Your reimbursement will be based on Guardian's fee schedule for Your specific Policy or on a percentile of the prevailing fee data for the Dentist's zip code. Please refer to Your Schedule of Benefits.

B400.0190

Option E

COVERED CHARGES

To be a Covered Charge, the service must be:

- Performed by a licensed Dentist; and
- Necessary and appropriate for Your condition; and
- An eligible Covered Service as described in the Schedule of Benefits.

We may use the professional review of a licensed Dentist to determine the appropriate benefit for a dental procedure or course of treatment. We may apply an Alternate Treatment benefit when a less expensive service can be used to treat the dental condition.

Certain comprehensive dental services have multiple procedures. For benefit purposes, these separate procedures will be considered part of the more comprehensive service.

You and Your Dentist have the right and responsibility for choosing the course of treatment and the services to be performed, regardless if those services are covered under this Policy. Once services have been performed and the claim submitted, We will review the claim and determine the benefits payable under this Policy.

All covered charges are considered incurred on the date services are furnished, with the following exceptions:

- Charges for crowns, bridges and other cast restorations are incurred on the date the tooth is initially prepared.
- Charges for root canals are incurred on the date the pulp chamber is opened.
- Charges for dentures are incurred on the date the final impression is made.
- The initial charge for orthodontic treatment is incurred on the date the Appliance is first placed.

Please refer to Your Schedule of Benefits.

B400.0191

Option E

Continuity Of Care

At Your request, We can arrange for the completion of Covered Services by a terminated Dentist for the duration of an Acute Condition. A terminated Dentist means a Dentist whose contract to provide services to Covered Persons is terminated or not renewed by Us or one of Our contracting dental groups. A terminated Dentist is not a Dentist who voluntarily leaves Us or Our contracting dental group. You must be undergoing a course of treatment for an Acute Condition and Your coverage under the Policy must continue during the completion of Covered Services.

Pre-Treatment Review

To assist You in managing Your total costs, Guardian offers a "Pre-Treatment Review".

A Dentist may submit a treatment plan to Guardian for review before services are performed. Guardian will advise the patient and the Dentist what services are covered and what the estimated payment would be. The actual payment for the predetermined services depends on eligibility, Policy limitations, Coordination of Benefits and the remaining maximum available at the time services are performed. A Pre-Treatment Review is subject to change based on the Dentist's participation status at the time of treatment. A Pre-Treatment Review is optional, however it is strongly recommended for non-routine dental services. Once the services are completed, the claim should be submitted to Guardian for payment.

B400.3343

Option E

Benefit Year Maximum Rollover

A portion of a Covered Person's unused Benefit Year Maximum may be rolled over into a maximum rollover account.

At the beginning of each Benefit Year, a maximum rollover reward will be made, provided:

- The Covered Person had a claim incurred and paid during the prior Benefit Year.
- The Covered Person's paid claims for the prior Benefit Year did not exceed the rollover threshold amount.
- The Covered Person must have been eligible for major service coverage at the end of the prior Benefit Year. Please refer to your Schedule of Benefits for covered major services.
- The Covered Person must have been insured with the rollover provision prior to October of the prior year.

The amount of any maximum rollover reward is listed in the Schedule of Benefits. In addition, there will be a bonus rollover reward provided if all of the claims submitted during the Benefit Year are for services provided by a Dentist in the Tier 1 Coverage level.

If a Covered Person reaches his or her Benefit Year Maximum, We will pay additional benefits up to the amount stored in the Covered Person's rollover account. Rollover benefits are not available for orthodontic services. The amount stored in the rollover account cannot be greater than the rollover account maximum.

The rollover threshold, maximum rollover reward, bonus rollover reward and the rollover account maximum are listed in the Schedule of Benefits.

A Covered Person's rollover account will be eliminated and any accrued rollover lost, if he or she has a break in coverage of any length of time, for any reason.

B400.0218

Option E

Replacing a Prior Policy

If this Policy is replacing a Prior Policy, in the first Policy year; (a) We will reduce the Deductible amount applied under the Prior Policy from this Policy's Deductible; and (b) the maximum amount paid under the Prior Policy will be deducted from this Policy's Benefit Year Maximum. Documentation for Prior Policy benefits must be provided.

B400.0193

Option E

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B400.0292

Option E

**Active Work or
Actively At Work or
Actively Working:** These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, at:

- One of the Employer's usual places of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and the Employer have agreed on for Your work.

B400.0335

Option E

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

B400.3344

Option E

Alternate Treatment: This term means 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 through the professional review of a licensed Dentist.

B400.0294

Option E

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

B400.0295

Option E

Appliance: This term means any dental device other than a Dental Prosthesis.

B400.0296

Option E

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

B400.0361

Option E

Benefit Year Maximum: This term means the total dollar amount that Guardian will pay for Covered Services by a Covered Person in a Benefit Year.

B400.0298

Option E

Certificate: This term means this Certificate of Coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Certificate.

B400.0299

Option E

Coinsurance: This term means the percent of the benefit that Guardian will pay after the required Deductible has been met.

B400.0303

Option E

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Guardian to participate in Guardian's dental network.

B400.0300

Option E

Copayment: This term means a fixed dollar amount that the Covered Person is required to pay at the time services are rendered.

B400.0304

Option E

Covered Person: This term means You, if You are covered by this Policy, and any of Your covered dependents.

B400.0301

Option E

Covered Services: This term means services for which any reimbursement is available under the Employee's Certificate of Coverage, regardless of whether the reimbursement is contractually limited by a Deductible, Copayment, Coinsurance, service waiting period, Benefit Year Maximum or Lifetime Maximum, frequency, alternate benefit payment, or other limitations.

B400.0363

Option E

Deductible: This term means a fixed dollar amount the Covered Person is responsible for paying before Guardian will begin paying the cost of covered benefits.

B400.0305

Option E

Dental Prosthesis: This term means a restoration or device which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of: (1) bridge retainer crowns, inlays, and onlays; (2) bridge pontics; (3) complete and immediate dentures; (4) partial dentures; and (5) (a) crowns; (b) inlays (c) onlays (d) veneers; (e) implants; and (f) posts and cores.

B400.0306

Option E

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or certificate and covered by this Policy.

B400.0307

Option E

Effective Date: The date the Policy goes into force and effect as stated on the cover page of the Certificate of Coverage, or any change to the Policy as requested by the Employer and approved by Us and in force and effect as stated on cover page of the Certificate of Coverage.

B400.0312

Option E

Eligibility Date: This term means the earliest date You are eligible for coverage under this Certificate as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Certificate.

B400.0313

Option E

Employee: This term means the member of the group determined to be eligible by the Employer.

B400.0310

Option E

Employer: This term means the entity that purchased this Policy.

B400.0311

Option E

Full-time: This term means:

You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 20 hours per week), at:

- Your Employer's place of business;
- Some place where the Employer's business requires You to travel; or
- Any other place You and Your Employer have agreed upon for the performance of Your job.

B400.0318

Option E

Injury: This term means: (1) all damage to a Covered Person's mouth due to an accident which occurs while he or she is covered by this Policy; and (2) all complications arising from that damage. But the term does not include damage to teeth, Appliances or Dental Prostheses which results solely from chewing or biting food or other substances.

B400.0316

Option E

Late Entrant: This term means a person who: (1) becomes covered by this Policy more than 31 days after the Covered Person is eligible; or (2) becomes covered again, after the Covered Person's coverage lapsed because he or she did not make required payments.

B400.0319

Option E

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Guardian to provide dental services

B400.0321

Option E

Policy: This term means the group Dental Insurance Coverage described in the Policy and this Certificate.

B400.0324

Option E

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

B400.0326

Option E

Prior Policy: This term means the Employer's plan of group dental coverage which was in force immediately prior to this Policy. For a plan to be considered a Prior Policy, the Guardian Policy must start immediately after the prior coverage ends.

B400.0328

Option E

Qualifying Event: This term means a specific occurrence that changes a Covered Person's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental plan; divorce; death of Your Spouse; termination of another dental policy; or any other event as required by state or federal law or in accordance with Your Employer's rules.

B400.0330

Option E

Spouse: This term means the person to whom You are legally married, or Your registered domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your registered domestic partner, civil union partner or equivalent was recorded.

B400.3424

Option E

We, Us, Our and Guardian: These terms mean The Guardian Life Insurance Company of America.

You, Your or Yourself: These terms mean the covered Employee.

B400.0334

Option E

STATEMENT OF ERISA RIGHTS

The Guardian Life Insurance Company of America

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- (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.

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Benefits 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 dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or You may contact them in your telephone directory.

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

If you have questions about this section, see your plan administrator.

Statement of Erisa Rights (Cont.)

Dental Benefits
Claims Procedure Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

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

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

B400.0450

Option E

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

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

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

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

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

Adverse Benefit Determination

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

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific provisions in the Policy, Certificate, plan or other documents, on which the determination is based;
- A description of any additional material or information necessary to reconsider the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim review procedures which a claimant may follow to have a claim for benefits reviewed and the time limits applicable to such procedures;
- Identification and description of any specific internal rule, guideline or protocol that was relied upon in making an Adverse Benefit Determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an Adverse Benefit Determination on appeal, and;
- In the case of an Adverse Benefit Determination based on medical necessity or experimental treatment, either 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.

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. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

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

In reviewing an appeal, Guardian will:

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

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

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

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

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

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

B400.0451

The Guardian Life Insurance Company of America

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

OPTION E		
GROUP DENTAL INSURANCE COVERAGE SCHEDULE OF BENEFITS		
This Schedule of Benefits is attached to the Certificate and is effective the later of: 1) the Policy Effective Date or; 2) the Effective Date of any amendment. This Schedule of Benefits replaces any previously issued Schedule of Benefits.		
Benefit Level	Tier 1	Tier 2
Tier Configuration	DentalGuard Preferred Gold Dentists DentalGuard Preferred Silver Dentists	Non-Contracted Dentists
Guardian's Preferred Provider Organization consists of Dentists in the DentalGuard Preferred ("DGP") network. The network is configured into various tiers representing specific benefit levels which will be reimbursed as shown below. Network access varies by geographic location and zip code. Please visit www.guardianlife.com to confirm your Dentist's tiered participation.		
IMPORTANT: If You opt to receive dental services that are not Covered Services under this Policy, a Contracted Dentist may charge You his or her usual and customary rate for those services. Prior to providing You with dental services that are not a covered benefit, the Dentist should provide to You a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If You would like more information about dental coverage options, You may call Our Customer Response Unit at 800-541-7846 or Your insurance broker. To fully understand Your coverage, You may wish to carefully review this evidence of coverage document.		
Covered Charges Reimbursement	DentalGuard Preferred Gold - Contracted Fee Schedule DentalGuard Preferred Silver - Contracted Fee Schedule	Non-Contracted Dentists: DentalGuard Preferred Gold - Contracted Fee Schedule
Dependent Child Age Limit	26	26
PLAN BENEFITS		
Your Benefit Year is the 12 month period which starts on January 1st and ends on December 31st of each year.		
BENEFIT YEAR DEDUCTIBLE		
Individual Benefit Year Deductible - A covered family must meet three Individual Benefit Year deductibles in a Benefit Year	\$50.00	\$50.00
Deductible Waived for Preventive Services	Yes	Yes
Deductible Waived for Basic Services	No	No

BENEFIT YEAR DEDUCTIBLE (Cont.)		
Deductible Waived for Major Services	No	No
COINSURANCE		
Preventive Services	100%	80%
Basic Services	80%	80%
Major Services	50%	50%
BENEFIT YEAR MAXIMUM		
Individual Benefit Year Maximum	\$2,000.00	\$2,000.00
Covered charges used to satisfy the Deductible(s) and Maximum(s) will apply to all benefit levels.		
BENEFIT YEAR MAXIMUM ROLLOVER		
Rollover Threshold	\$800.00	\$800.00
Maximum Rollover Reward	\$400.00	\$400.00
Bonus Rollover Reward	\$600.00	\$0.00
Rollover Account Maximum	\$1,500.00	\$1,500.00
LATE ENTRANT PENALTIES		
Preventive Services	None	None
Basic Services	6 months	6 months
Major Services	12 months	12 months

COVERED DENTAL SERVICES		
The listing below is a partial list of covered dental services and limitations. Additional dental services that are not named on this list may also be eligible for coverage. Covered dental services are based on current dental terminology and are updated periodically. The most current dental terminology may not be reflected in the list of covered dental services. Benefits will be payable based on the most current dental terminology.		
SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
DIAGNOSTIC AND PREVENTIVE		
Office visits, Oral evaluations	Preventive	Limited to 1 in 6 months. Comprehensive evaluations are included in the frequency with office visits and oral evaluations. Limited to 1 in 36 months.
After hours office visits or Emergency palliative treatment	Preventive	Limited to 1 in 6 months. Covered only if no other treatment, other than radiographic images, is performed during the visit.
Complete series of radiographic images (at least 14 films, including bitewings) or Panoramic radiographic image	Preventive	Limited to 1 in 60 months.
Intraoral periapical images, Occlusal radiographic images	Preventive	Limited to single films.
Bitewing radiographic images	Preventive	Limited to either a maximum of 4 bitewing radiographic images or vertical bitewings (7-8 radiographic images), in one visit, once in 12 months.
Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	Not Covered	
Diagnostic casts	Basic	Covered 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 and onlays or full mouth equilibration.
Prophylaxis	Preventive	Limited to 1 prophylaxis or periodontal maintenance in 6 months. Also see Periodontal Maintenance under Periodontics.
Prophylaxis - medically necessary	Preventive	Limited to 1 in 12 months. Covered when needed due to a medical condition. Written verification from the medical physician is required.
Fluoride	Preventive	Limited to 1 in 6 months. Limited to covered persons up to age 19.
Sealants	Basic	Limited to unrestored, permanent molar teeth. Limited to once per tooth in 36 months. Limited to Covered Persons up to age 16.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Space maintainers	Basic	Limited to the initial Appliance only. For Covered Persons up to age 16. Covered when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes adjustments in the first 6 months after insertion. Limited to a maximum of one bilateral per arch or one unilateral per quadrant.
Minor treatment to control harmful habits	Basic	For Covered Persons up to age 14. Limited to thumbsucking Appliances. Limited to the initial Appliance only.
RESTORATIVE		
Amalgam restorations	Basic	Allowance includes bonding agents, liners, bases, polishing and local anesthetic. Benefits for the replacement of existing restorations will 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.
Resin-based composite restorations	Basic	Allowance includes resin bonding agents, liners, bases, acid etching, light curing and local anesthetic. Limited to Anterior Teeth. The benefit for the corresponding amalgam restoration will be allowed on Posterior Teeth. Benefits for the replacement of existing restorations will 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.
Prefabricated stainless steel crowns, Prefabricated resin crowns	Basic	Limited to once per tooth in 24 months. Prefabricated crowns are considered to be a temporary or provisional service when done within 24 months of a permanent crown and considered to be part of the permanent restoration.
Crowns	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. See Dental Prosthesis replacement limitation below. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Inlays, Onlays, Labial veneers	Major	Covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or resin-based composite filling material. Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. Veneers are limited to anterior and bicuspid teeth only. See Dental Prosthesis replacement limitation below. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Post and core, Core buildup	Major	Covered when done in conjunction with a covered crown or bridge retainer and only when necessitated by substantial loss of natural tooth structure. Limited to permanent teeth only. See Dental Prosthesis replacement limitation below.
Crown repair, Bridge repair	Major	
Re-cement or re-bond inlay, onlay, labial veneer, crown, post and core or bridge	Major	If performed more than 12 months after initial insertion.
ENDODONTICS		
Allowance includes diagnostic, treatment and final radiographic images, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.		
Pulp cap - direct, Pulp cap - indirect	Basic	Limited to permanent teeth and limited to one pulp cap per tooth. Indirect pulp cap includes allowance for sedative filling.
Pulpotomy	Basic	Covered when root canal therapy is not the definitive treatment.
Root canal/endodontic therapy, anterior and bicuspid teeth	Basic	
Root canal/endodontic therapy, molar teeth	Basic	
Retreatment of previous root canal therapy, anterior and bicuspid teeth	Basic	Limited to once per tooth.
Retreatment of previous root canal therapy, molar teeth	Basic	Limited to once per tooth.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Apicoectomy, Root amputation, Retrograde filling	Basic	Each limited to once per root.
Other endodontic services	Basic	
PERIODONTICS		
Non-surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Periodontal maintenance	Basic	Limited to 1 prophylaxis or periodontal maintenance in 6 months. Also see Prophylaxis under "Diagnostic and Preventive Services".
Periodontal scaling and root planing	Basic	Limited to once per quadrant in 24 months. Covered when there is radiographic image and pocket charting evidence of bone loss.
Full mouth debridement	Basic	Limited to once per lifetime.
Surgical periodontics - Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographic images and pocket depth probing of each tooth involved.		
Gingivectomy or gingivoplasty (1 to 3 contiguous teeth) or Crown lengthening	Basic	Limited to a total of one service, per tooth, in 12 months.
Gingivectomy or Gingivoplasty (4 or more teeth per quadrant), Osseous surgery, Gingival flap procedure, Distal or proximal wedge, or Surgical revision procedure	Basic	Limited to a total of one service, per quadrant, in 36 months.
Tissue grafts	Basic	Limited to a total of one service, per tooth or site, in 36 months. Covered when the tooth is present or when dentally necessary as part of a covered surgical placement of an implant.
Guided tissue regeneration	Basic	Limited to once per area or tooth, when the tooth is present.
Bone replacement graft	Basic	Limited to once per area or tooth, when the tooth is present.
PERIODONTAL SURGERY RELATED		
Occlusal adjustment - limited	Basic	Covered when done within 6 months after covered periodontal scaling and root planing or osseous surgery. Limited to a total of two visits.
Occlusal guard	Basic	Covered when done within 6 months after osseous surgery. Limited to one per lifetime.
PROSTHODONTICS		

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Fixed partial denture retainer crowns and pontics (Bridge)	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. See Dental Prosthesis replacement limitation and missing tooth provision below. Each retainer and each pontic makes up a unit on a bridge. Allowance includes insulating bases, temporary or provisional restorations, local anesthetic and associated gingival involvement.
Dentures, complete and partial	Major	Allowance includes adjustments done by the Dentist furnishing the denture in the first 6 months after installation and all temporary or provisional dentures. Temporary or provisional full and partial dentures, and interim dentures older than 1 year are considered to be a permanent Dental Prosthesis. Limited to permanent teeth only. See Dental Prosthesis replacement limitation and missing tooth provision below.
Adding teeth to partial dentures	Major	To replace extracted natural teeth. See missing tooth provision below.
Denture repairs	Major	
Denture rebase	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to rebases done more than 12 months after the insertion of the denture.
Denture reline	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Once per denture in 24 months. Limited to relines done more than 12 months after the insertion of the denture.
Denture adjustments	Major	Considered part of the denture placement if performed within 6 months by the Dentist who furnished the denture. Limited to adjustments done more than 6 months after a denture rebase, denture reline or the initial insertion of the denture.
Tissue conditioning	Major	Considered part of the denture placement if performed within 12 months by the Dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in 12 months.
IMPLANT SERVICES		
Radiographic/surgical implant index, by report	Major	Limited to once per arch in 24 months.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Surgical placement of implant	Major	The number of implants We cover is limited to the number of teeth extracted while insured under this Policy. Limited to the replacement of permanent teeth. See Dental Prosthesis replacement limitation and missing tooth provision below. Allowance includes the treatment plan, local anesthetic and post-surgical care.
Bone replacement graft for ridge preservation, per site	Major	Covered when done in conjunction with a covered surgical placement of an implant in the same site. Limited to once per tooth.
Prefabricated abutment, Custom fabricated abutment	Major	See Dental Prosthesis replacement limitation and missing tooth provision below.
Repair implant supported prosthesis	Major	
Repair implant abutment	Major	
Implant removal	Major	
Implant/abutment supported crown or retainer for fixed partial denture	Major	Limited to permanent teeth only. Porcelain is not covered on molars. If titanium or high noble metal (gold) is used, the benefit will be based on the noble metal benefit. See Dental Prosthesis replacement limitation and missing tooth provision below.
Implant/abutment supported fixed and removable dentures for completely or partially edentulous arch	Major	Limited to permanent teeth only. See Dental Prosthesis replacement limitation and missing tooth provision below.
ORAL AND MAXILLOFACIAL SURGERY		
Non-surgical extractions: Erupted tooth or exposed roots	Basic	Allowance includes the treatment plan, local anesthetic and post-treatment care.
Complex surgical extractions: Surgical removal of erupted teeth, Removal of impacted teeth, Surgical removal of residual tooth roots	Major	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.

SERVICE/PROCEDURE	CATEGORY OF SERVICE	LIMITATIONS
Other complex oral surgical services, including but not limited to: Alveoloplasty, Incision and drainage of abscess, Incisional biopsy of oral tissue.	Major	Allowance includes diagnostic and treatment radiographic images, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by Your medical plan.
ADJUNCTIVE GENERAL SERVICES		
Anesthesia: General anesthesia/deep sedation, Intravenous moderate (conscious) sedation, Non-intravenous (conscious) sedation, Inhalation of nitrous oxide.	Major	Covered in conjunction with covered surgical services.
Therapeutic parenteral drugs	Basic	Covered when needed solely for treatment of a dental condition.
Consultations	Basic	Diagnostic consultation with a Dentist other than the one providing treatment. Limited to one consultation for each covered dental specialty in 12 months. Covered only when no other treatment, other than radiographic images, is performed during the visit.
GENERAL LIMITATIONS		
Missing tooth provision	A Dental Prosthesis will not be covered when replacing a tooth or teeth lost or extracted before being covered under this Plan unless they were extracted while covered by the Prior Plan.	
Dental Prosthesis replacement limitation	We will not pay to replace an existing Dental Prosthesis with any Dental Prosthesis unless: (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the Covered Person's mouth in an Injury suffered while covered, and cannot be made serviceable. See Dental Prosthesis in the Definitions section of the Certificate.	

EXCLUSIONS
We will not pay for:
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 Medi-Cal, paid for or sponsored by any governmental body.
Any service or procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
Any service or procedure performed in conjunction with, as part of, or related to a service or procedure which is not covered by this Plan.
Any service or procedure performed on a tooth or teeth with a guarded, questionable or poor prognosis.
Any restoration, procedure, Appliance or Dental Prosthesis used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
Educational services, including, but not limited to: (1) oral hygiene instructions; (2) tobacco counseling; or (3) nutritional counseling.
Duplication of radiographic images, the completion of claim forms, OSHA or other infection control charges.
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, that is incidental to or results from a medical condition.
Any service or procedure furnished solely for cosmetic reasons. This includes the characterization and personalization of a Dental Prosthesis, odontoplasty and bleaching of discolored teeth.
Replacement of a lost, missing or stolen Appliance or Dental Prosthesis or the fabrication of a spare Appliance or Dental Prosthesis.
The replacement of extracted or missing third molars/wisdom teeth.
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.
Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
Temporary or provisional Dental Prosthesis or Appliance except interim partial dentures to replace Anterior Teeth extracted while covered under this Plan.
Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
The localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
Application of desensitizing medicaments and desensitizing resins for cervical and/or root surface.
Bite registration, bite analysis or occlusion analysis - mounted case.
Detailed and extensive oral evaluations.
Cephalometric radiographic images.
Oral/facial photographic images.
Separate charges for local anesthetic.
Cone beam images.
Pulp vitality tests.
Caries susceptibility tests.
Prescription medication.
Specialized techniques.
Precision attachments.

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and is effective on 07/01/2017.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Guardian's Preferred Provider Organization has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

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

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

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

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

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

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

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

If You have any questions or want to request an interpreter, please call Our Customer Response Unit at 1-800-541-7846 or the toll-free number on Your ID card.

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

The Guardian Life Insurance Company of America

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

Michael Prestileo, Senior Vice President

B434.1346

Option E

AMENDATORY RIDER

This Rider amends the Certificate and Policy as follows and is effective on the later of the Policy Date or the date requested by the Policyholder.

The definition of **Spouse** is replaced with the following:

Spouse: The person to whom You are legally married or Your **Domestic Partner** or civil union partner.

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry

Or

the same-sex or different-sex person with whom you have not registered your relationship if you satisfy the following requirements:

- You live and share financial assets and obligations with this person.
- This person is at least 18 years of age, is able to provide legal consent, and is not a blood relative.
- Neither you nor this person are in a marriage or domestic partnership with anyone else or legally separated from anyone else.
- You submit acceptable documentation that you meet the above criteria. An affidavit attesting to these facts may be required.

Except as specifically noted above for relationships that are not registered, **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0245

You May not be covered by all options in this Certificate.

This Certificate contains all the benefits and options that are available under the Policy. You are insured only for those benefits and options that you are eligible and enrolled for, and for which the required premium has been paid.

CERTIFICATE OF COVERAGE

Guardian

10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B815.0004

COMPLAINT NOTICE

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

**The Guardian Sales Office
4685 MacArthur Court, Suite 100
Newport Beach, California 92660
Telephone: (949) 453-9990
(800) 662-6464
Fax: (949) 453-9919**

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

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

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

B815.0314

TABLE OF CONTENTS

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

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

B815.0006

**Vision Care
Expense Insurance**

Eligibility for Vision Care Expense Coverage	CGP-CA-VSP-10
Employee Coverage	
Dependent Coverage	
Vision Care Benefits	

B815.0007

GENERAL PROVISIONS

As used in this certificate:

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

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

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

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

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

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

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

B815.0010

Limitation of Authority

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

Incontestability

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

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

B815.0014

Vision Claims Provisions

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

Notice Written notice of an injury or sickness for which a claim is being made must be given to *us* within 20 days of the date the injury occurs or the sickness starts. This notice should include *your* name and *plan* number. If the claim is being made for one of *your* covered dependents, the dependent's name should also be noted.

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

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

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

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

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

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

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

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

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

When proof of loss is filed, *you* or any other payee may direct *us*, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. But, we can not require that a particular provider provide such care. And, *you* or any other payee may not assign *your* right to take legal action under this *plan* to such provider.

Vision Claims Provisions (Cont.)

- Examination and Autopsy** We have the right to have a doctor of *our* choice examine the person for whom a claim is being made under this *plan* as often as *we* feel necessary. And *we* have the right to have an autopsy performed in the case of the death, where allowed by law. We will pay for all such examinations and autopsies.
- Legal Actions** No legal action against this *plan* will be brought until 60 days from the date proof of loss has been given as stated above. And, no legal action will be brought against this *plan* after 3 years from the date written proof of loss is required to be given.
- Workers' Compensation** The vision benefits provided by this *plan* are not in place of, and do not affect requirements for coverage by Workers' Compensation.

B815.0015

All Options

Repayment

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

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

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

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

As used in this provision:

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

Repayment (Cont.)

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

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

B815.0017

YOUR CONTINUATION RIGHTS

Coordination Between Continuation Sections

A *covered person* may be eligible to continue his or her group health benefits under this *plan's* "Federal Continuation Rights" section and under other continuation sections of this *plan* at the same time. If he or she chooses to continue his or her group health benefits under more than one section, the continuations:

- (a) start at the same time;
- (b) run concurrently; and
- (c) end independently, on their own terms.

A *covered person* covered under more than one of this *plan's* continuation sections:

- (a) will not be entitled to duplicate benefits; and
- (b) will not be subject to the premium requirements of more than one section at the same time.

B815.0018

An Important Notice About Continuation Rights

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

B815.0019

Federal Continuation Rights

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

This provision applies only to any vision coverage which is part of this *plan*. In this provision, this coverage is referred to as "group health benefits."

Federal Continuation Rights (Cont.)

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

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

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

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

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

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

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

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

B815.0272

All Options

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

B815.0024

All Options

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

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

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

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

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

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

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

B815.0025

All Options

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

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

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

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

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

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

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

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

Federal Continuation Rights (Cont.)

When Continuation Ends	A qualified continuee's continued group health benefits end on the first of the following: (1) with respect to continuation upon <i>your</i> 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 <i>your</i> death, <i>your</i> legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end; (4) with respect to a dependent whose continuation is extended due to <i>your</i> entitlement to Medicare while the dependent is on continuation, the end of the 36 month period which starts on the date the group health benefits would otherwise end; (5) the date the <i>employer</i> ceases to provide any group health <i>plan</i> to any <i>employee</i>; (6) the end of the period for which the last premium payment is made; (7) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or (8) the date, after the date of election, he or she becomes entitled to Medicare.
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B815.0026

All Options

GLOSSARY

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

General Definitions

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

B815.0030

All Options

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

B815.0031

All Options

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

B815.0032

All Options

Full-time means *you* regularly work at least the number of hours in the normal work week set by *your employer* (but not less than 20 hours per week), at *your employer's* place of business.

B815.0034

All Options

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

B815.0035

All Options

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

B815.0036

All Options

Definitions Applicable to Vision Care Expense Coverage

B815.0039

All Options

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

B815.0040

All Options

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

B815.0041

All Options

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

B815.0042

All Options

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

B815.0043

All Options

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

B815.0044

All Options

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

B815.0045

All Options

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

B815.0046

All Options

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

B815.0047

All Options

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

B815.0048

All Options

Necessary Contact Lenses are contact lenses needed:

- (a) following cataract surgery;
- (b) to correct extreme visual acuity problems that can not be corrected spectacle lenses;
- (c) for certain conditions of anisometropia; or
- (d) for keratoconus.

B815.0049

All Options

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

B815.0050

All Options

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

B815.0051

All Options

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

B815.0052

All Options

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

B815.0053

All Options

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

B815.0054

All Options

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

B815.0055

All Options

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

B815.0056

All Options

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

B815.0057

All Options

Standard Lenses mean regular glass or plastic lenses.

B815.0058

All Options

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

B815.0059

All Options

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

B815.0060

All Options

The Guardian Life Insurance Company of America

VISION CARE EXPENSE INSURANCE

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

B815.0062

All Options

Employee Coverage

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

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

This *plan's* vision open enrollment period occurs from November 1st to November 30th of each year.

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

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

B815.0067

All Options

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

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

B815.0091

All Options

When Your Coverage Ends Your coverage ends on the last day of the month in which *you* cease *active work* for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date *you* die.

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

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

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

B815.0093

All Options

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

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

B815.0264

All Options

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

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

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

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

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

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

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

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

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

B815.0099

All Options

Dependent Coverage

B815.0100

All Options

Eligible Dependents For Dependent Vision Care Benefits

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

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

B815.0102

All Options

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

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

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

B815.0104

All Options

Handicapped Children *You* may have a child with a mental or physical handicap, or developmental disability, who is chiefly dependent upon *you* for support and maintenance. Subject to all of the terms of this coverage and the *plan*, such a child may stay eligible for dependent benefits past this coverage's age limit, subject to the conditions shown below.

- His or her condition started before he or she reached this coverage's age limit.
- He or she became Covered for dependent vision benefits before he or she reached the age limit, and remained continuously covered until he or she reached the age limit.
- He or she is unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon you for most of his or her support and maintenance.
- You send us written proof of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, we can ask for periodic proof that the child's condition continues, but we cannot ask for this proof more than once a year.

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

B815.0106

All Options

When Dependent Coverage Starts

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

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

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

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

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

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

B815.0107

All Options

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

B815.0109

All Options

Newborn Children

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

B815.0110

All Options

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

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

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

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

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

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

B815.0322

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

B815.0118

VISION CARE BENEFITS

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

B815.0122

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

Vision Service Plan This *plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care *preferred provider* organization (PPO).

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

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

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

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

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

Choice of Preferred Providers When a person becomes enrolled in this *plan*, he or she will receive a list of VSP *preferred providers* in his or her area. A *covered person* may receive vision services from any VSP *preferred provider*.

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

Vision Service Plan

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

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

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

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

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

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

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

The amount of, and the requirement for payment of copayments during the period of completion of covered services with a terminated provider are the same as would be paid by the covered person if receiving care from a provider currently contracted with VSP.

Vision Service Plan

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

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

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

B815.0124

All Options

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

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

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

B815.0127

All Options

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

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

Vision Service Plan

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

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

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

- (1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.
- (2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.
- (3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person*. Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.
- (4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.
- (5) All complaints will be retained in the Professional Relations Department.

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

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

B815.0128

How This Plan Works

We pay benefits for the covered charges a *covered person* incurs as follows. The services and supplies covered under this *plan* are explained in the "Covered Services and Supplies" section of this *plan*. What we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

Services or Supplies From a Preferred Provider

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

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

- For each vision examination from a *preferred provider* \$10.00
- For each pair of *standard frames* and/or
standard lenses from a *preferred provider* \$25.00
- For necessary contact lenses from a *preferred provider* \$25.00

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

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

- For covered services and supplies 100%

B815.0141

Services or Supplies From a Non-Preferred Provider

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

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

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

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

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

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

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

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

For covered services and supplies 100%

B815.0142

All Options

Covered Charges

Covered charges are the charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges. If more than one type of service can be used to treat a condition, we have the right to base benefits on the least expensive service or supply.

Covered Services and Supplies

This section lists the types of charges we cover. But what we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

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

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

Covered Services and Supplies (Cont.)

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

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

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

B815.0131

All Options

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

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

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

B815.0151

All Options

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

B815.0171

All Options

Standard Frames We cover charges for standard frames.

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

Covered Services and Supplies (Cont.)

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

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

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

B815.0197

All Options

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

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

B815.0205

All Options

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

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

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

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

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

B815.0214

Special Limitations

**If this VSP Plan
Replaces Another
VSP Plan**

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

B815.0227

Exclusions

We won't pay for:

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

B815.0231

We won't pay for:

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

B815.0232

All Options

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

B815.0233

All Options

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

B815.0234

All Options

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

B815.0235

All Options

- We won't pay for blended lenses.

B815.0236

All Options

- We won't pay for high index lenses.

B815.0237

All Options

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

B815.0238

All Options

- We won't pay for oversized lenses.

B815.0239

All Options

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

B815.0240

All Options

- We won't pay for edge treatment.

B815.0241

All Options

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

B815.0242

All Options

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

B815.0243

All Options

- We won't pay for polycarbonate lenses.

B815.0244

All Options

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

B815.0245

SAMPLE BENEFIT CALCULATOR

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

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

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

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

Preferred Provider - Split Copayment Plan

Cost of Exam:	Paid by VSP
Copayment Applied to Exam:	\$10.00
Cost of Standard Lenses:	Paid by VSP
Cost of Standard Frames:	Paid by VSP
Copayment Applied to Lenses:	\$20.00
Copayment Applied to Frames:	\$20.00

Insured's Total Costs:	\$50.00
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Non-Preferred Provider - Split Copayment Plan

Cost of Exam:	\$65.00
Deductible Applied to Exam:	\$10.00
Remainder:	<u>\$55.00</u>
Exam Allowance:	\$35.00
Insured Pays Additional:	\$20.00

Cost of Lenses:	\$55.00
Deductible Applied to Lenses:	\$20.00
Remainder:	<u>\$35.00</u>
Lens Allowance:	\$25.00
Insured Pays Additional:	\$10.00
Cost of Frames:	\$80.00
Deductible Applied to Frames:	\$20.00
Remainder:	<u>\$60.00</u>

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

B815.0247

CERTIFICATE RIDER

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

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

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

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

As used herein:

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

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

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

All Options

CERTIFICATE RIDER

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

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

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

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

B531.0291

All Options

Standard Lenses - one pair in any one calendar year Period.

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

B505.1436

All Options

SERVICES AND SUPPLIES

Standard Frames - one set in any 2 calendar year Period.

AFFILIATE PROVIDER - COSTCO

Covered In full up to \$70.00.
● No discount available on charges in excess of the benefit amount.

OTHER AFFILIATE PROVIDERS

Covered In full up to \$130.00

B531.0324

All Options

Elective Contact Lenses - one set in any one calendar year Period.

- Contact Lens (Materials Only)

Covered In full up to \$130.00.

Covered In full up to \$130.00

B531.0326

All Options

Limitations and Exclusions:

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

B505.1566

All Options

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

B505.1447

All Options

Definitions:

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

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

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

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

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

The Guardian Life Insurance Company of America

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

Michael Prestileo, Senior Vice President

CGP-A-VSN-AFFIL-CA-13

B531.0319

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B815.0250

All Options

The Guardian's Responsibilities

B815.0252

All Options

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

B815.0253

All Options

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

B815.0255

Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

CGP-3-ERISA

B815.0256

Termination of This Group Plan

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

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

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

B815.0257

SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE

You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA:
EXTENDED CARE HOSPITAL OF WESTMINSTER Plan

- **Employer's Name:** (Plan Sponsor)

RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA:
EXTENDED CARE HOSPITAL OF WESTMINSTER

Address: 206 HOSPITAL CIRCLE
WESTMINSTER CA 92683

Phone Number: 714-821-1993

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**330690220

- **Plan Number:** 501

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA:
EXTENDED CARE HOSPITAL OF WESTMINSTER

Address: 206 HOSPITAL CIRCLE
WESTMINSTER CA 92683

Phone Number: 714-821-1993

- **Agent for the Service of Legal Process:**

RIVERSIDE MAGNOLIA CORP. AND MARK & FRED ENT. DBA:
EXTENDED CARE HOSPITAL OF WESTMINSTER

Address: 206 HOSPITAL CIRCLE
WESTMINSTER CA 92683

Phone Number: 714-821-1993

(Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.
- **Date of End of Record Year:** December 1st .
- **Sources of Contribution:**Contributions to the plan are provided by:
 - the Employer
 - the Employee
 - Both the Employer and the Employee (assuming there are situations where both contribute).
- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)
- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.
- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.
- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

B055.0383

All Options

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment.Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment.Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders.Guardian may use and disclose your PHI to contact you and remind you of appointments.

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Health Related Benefits and Services.Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors.Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0051

All Options

Guardian is required to use or disclose your PHI :

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you are incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

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- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

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

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

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All Options

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

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:

Guardian Corporate Privacy Officer
National Operations

Address:

The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

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YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.guardianlife.com

You can access helpful, secure information about your Guardian benefits online 24 hours a day, 7 days a week.

Anytime, anywhere you have internet access, you'll be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of your claim
- Print forms and plan materials
- And so much more!

To register, go to **www.guardianlife.com**

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

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