YOUR GROUP INSURANCE PLAN BENEFITS

GENESEO COMMUNITY UNIT SCHOOL DISTRICT 228
CLASS 0001
DENTAL, VISION

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

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

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

New Mexico Residents
Consumer Complaint Notice

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

httsp://www.osi.stat.nm.us/ConsumerAssistance/index.aspx

CCN-2019-NM B999.0042

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-R-STK-90-3 B110.0023

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COMPLAINT NOTICE

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

The Guardian Sales Office
11506 Nicholas Street, Suite 110
Omaha, Nebraska 68154
Telephone: (402) 498-3880
(800) 423-3978
Fax: (402) 498-3790

*****

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

CGP-3-ILDISC B120.0007

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

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

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

GENERAL PROVISIONS

As used in this booklet:

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

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

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

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

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

CGP-3-R-GENPRO-90 B160.0012

Limitation of Authority

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

CGP-3-R-LOA-90 B160.0004

Incontestability

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

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

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

CGP-3-R-INCY-90 B160.0003

Dental Claims Provisions

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

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

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

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

Payment of Benefits We'll pay all dental benefits to which you're entitled as soon as we receive written proof of loss.

We pay all dental benefits to you, if you're living. If you're not living, we have the right to pay all dental benefits to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services.

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

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

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

CGP-3-R-AHC-90 B160.0058

An Important Notice About Continuation Rights

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

CGP-3-R-NCC-87 B240.0064

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

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

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

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

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

Conversion

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

CGP-3-R-COBRA-96-1 B235.0623

If You Die While Insured

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

CGP-3-R-COBRA-96-2 B235.0075

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

CGP-3-R-COBRA-96-3 B235.0178

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

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

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

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

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

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

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

CGP-3-R-COBRA-96-4 B235.0198

Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4 B235.0195

Dependent Spouse Continuation Rights

Important Notice

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

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

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

If An Employee's Marriage Ends Or If An Employee Dies While Covered

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

If An Employee Retires While Covered

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

How And When To Continue The Group Health Benefits

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

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

The Employer's Responsibility

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

Guardian's Responsibility

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

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

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

Premiums

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

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

2. With respect to a retired employee's spouse or former spouse who has reached the age of 55 at the time continued group health benefits start:

   (a) For each month during the first two years of continued group health benefits: (i) an amount, if any, that would be charged an employee if the retired employee's spouse or the former spouse were a current employee of the employer; plus (ii) an amount, if any, that the employer would contribute toward the premium if the retired employee's spouse or the former spouse were a current employee.

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

When Continued Group Health Benefits End

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

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

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

The Right To Convert

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

Dependent Child Continuation Rights

Important Notice

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

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

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

If An Employee Dies While Covered

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

If A Dependent Child Reaches This Plan's Limiting Age

If an employee's dependent child reaches this plan's limiting age, he or she may continue this plan's group health benefits subject to all the terms and conditions below and to the timely payment of premiums. Such group health benefits may cover the child whose group health benefits would otherwise end.

How And When To Continue The Group Health Benefits

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

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

The Employer's Responsibility

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

Guardian's Responsibility

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

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

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

Premiums

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

When Continued Group Health Benefits End

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

(a) the end of the period for which the last premium payment was made;

(b) the date the child becomes covered for similar benefits under another group plan;

(c) the date the child's coverage would cease if he or she was still an eligible dependent of the employee; and

(d) the end of two years from the date the child's continued group health benefits began.

The Right To Convert

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

CGP-3-R-DCC-IL-04 B240.0254

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Employee Coverage

Eligible Employees

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

Other Conditions

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

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

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

CGP-3-EC-90-1.0 B489.0122

When Your Coverage Starts

Employee benefits are scheduled to start on your effective date.

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

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

CGP-3-EC-90-2.0 B489.0070

When Your Coverage Ends

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0 B489.0075

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

Important Notice

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

If Your Group Coverage Would End

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

When Continuation Ends

Coverage may continue until the earliest of the following:

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

Definitions

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

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

CGP-3-EC-90-3.0 B449.0727

Dependent Coverage

B200.0271

Eligible Dependents For Dependent Dental Benefits

Your *eligible dependents* are your (a) legal spouse; (b) unmarried dependent children who are under age 26; and (c) unmarried dependent children who are under age 30, if the children (i) are Illinois residents, (ii) served as members of the active or reserve components of any of the branches of the Armed Forces of the United States; and (iii) have received a release or discharge other than a dishonorable discharge.

Legal spouse includes a partner to a civil union when that union is in accordance with Illinois law. We treat the civil union partner as a spouse in marriage, and the civil union as a marriage. Such unions also include same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage.

CGP-3-DEP-90-2.0 B489.0447

Adopted Children And Step-Children

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

Dependents Not Eligible

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

CGP-3-DEP-90-3.0 B264.0007

Handicapped Children

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

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

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

The child's coverage ends when yours does.

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

Waiver Of Dental Late Entrants Penalty

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

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

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

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

When Dependent Coverage Starts

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

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

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

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

If you do this after the *enrollment period* for an *initial dependent* child, that child may not be enrolled until the next yearly dental dependent enrollment period. And, that child will be subject to any applicable late entrant penalties.

Once you have dependent coverage for your *initial dependents,* you must notify us when you acquire new dependents and agree to make any additional payments required for their coverage. If you do this within 31 days of the date a dependent is acquired, that dependent's coverage will start on the date the dependent first becomes eligible.

If you fail to notify us on time after having acquired a dependent spouse, the *newly acquired dependent* spouse, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The spouse's coverage is scheduled to start on the date the employee signs the enrollment form.

If you fail to notify us on time after having acquired a dependent child, the *newly acquired dependent* child may not be enrolled until the next yearly dental dependent enrollment period. And, that child will be subject to any applicable late entrant penalties.

The yearly dental dependent enrollment period is a period that begins 30 days prior to the plan's renewal date and ends on the plan's renewal date.

CGP-3-DEP-90-6.0 B489.0291

Exception

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

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

Newborn Children

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

CGP-3-DEP-IL-93 B489.0007

When Dependent Coverage Ends

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

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

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

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

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

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

CGP-3-DEP-90-9.0 B489.0269

DENTAL HIGHLIGHTS

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

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

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

CGP-3-DENT-HL-90 B497.0075

- **Payment Rates:**

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

CGP-3-DENT-HL-90 B497.0087

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

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

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

CGP-3-DENT-HL-90 B497.1431

Group Enrollment Period

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

CGP-3-DENT-HLTS B497.2407

DENTAL EXPENSE INSURANCE

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

CGP-3-DG2000 B498.0007

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in this *plan's* List of Covered Dental Services. To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

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

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

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

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

CGP-3-DGY2K-CC B498.0070

Alternate Treatment

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

Proof Of Claim

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

CGP-3-DGY2K-AT B498.0002

Pre-Treatment Review

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

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

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

Pre-Treatment Review (Cont.)

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

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

CGP-3-DGY2K-PTR B498.0004

Benefits From Other Sources

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

CGP-3-DGY2K-OS B498.0005

The Benefit Provision - Qualifying For Benefits

CGP-3-DGY2K-BEN B498.0072

Penalty For Late Entrants

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

- All Group II Services.

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

- All Group III Services.

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

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

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

CGP-3-DGY2K-LE B498.0232

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

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

A *benefit year* deductible of $50.00 applies to Group II and III services. Each *covered person* must have covered charges from these service groups which exceed the deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

Once a *covered person* meets the deductible, *we* pay for his or her Group II and III covered charges above that amount at the applicable *payment rate* for the rest of that *benefit year.*

CGP-3-DGY2K-BP B498.0187

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,000.00.

CGP-3-DGY2K-BP B498.0192

The Benefit Provision - Qualifying For Benefits

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Definitions of terms used in this provision:

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

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

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

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

Non-Orthodontic Family Deductible Limit

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

CGP-3-DGY2K-FL B498.0073

Payment Rates

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

- Benefits for Group I Services 100%
- Benefits for Group II Services 50%
- Benefits for Group III Services 50%

CGP-3-DGY2K-PR B498.0082

After This Insurance Ends

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

CGP-3-DGY2K-END B498.0234

Special Limitations

CGP-3-DGY2K-LMT B498.0138

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan

A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan. We* won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan.*

CGP-3-DGY2K-TL B498.0133

If This Plan Replaces The Prior Plan

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

Special Limitations (Cont.)

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan;* and (b) for which extraction benefits were paid by the *prior plan.*

- **Deductible Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's* deductibles required under this *plan,* by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.

- ***Benefit Year*** **Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan,* we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan.* The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

Exclusions

We will not pay for:

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

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

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

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

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

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

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

- The use of local anesthetic.

- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan.*
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or un-like *appliance* or *dental prosthesis;* unless (1) it is at least 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 insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.

- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are payable by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*

CGP-3-DGY2K-EXCH B498.2127

List of Covered Dental Services

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

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

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Group I - Preventive Dental Services

(Non-Orthodontic)

Prophylaxis And Fluorides

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

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to *covered persons* under age 14 and limited to 1 treatment(s) in any 6 consecutive month period.

Office Visits, Evaluations And Examination

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

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

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

CGP-3-DNTL-90-14 B498.4802

Space Maintainers

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

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

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

Fixed And Removable Appliances

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

CGP-3-DNTL-90-14 B498.0164

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

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

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

Other diagnostic radiographs:

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

Intraoral periapical or occlusal films - single films

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

CGP-3-DNTL-90-14 B498.0166

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

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

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

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration
Composite resin

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

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

CGP-3-DNTL-90-15 B498.1123

Crown And Prosthodontic Restorative Services

Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

Denture repairs, metal
Denture repairs, acrylic
Denture repair, no teeth damaged
Denture repair, replace one or more broken teeth
Replacing one or more broken teeth, no other damage

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

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

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

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

CGP-3-DNTL-90-15 B498.1122

Non-Surgical Extractions

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

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

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Other Services

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

Injectable antibiotics needed solely for treatment of a dental condition.

CGP-3-DNTL-90-15 B498.0206

Major Restorative Services

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

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

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

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

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

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

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

Other Implant services

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

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Prosthodontic Services

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

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

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

Bridge Pontics
Resin with metal
Porcelain
Porcelain with metal
Full cast metal

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

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Endodontic Services

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

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

Vital pulpotomy, only when root canal therapy is not the definitive treatment
Gross pulpal debridement
Pulpal therapy, limited to primary teeth only coinsurance
Root Canal Treatment
Root canal therapy
Root canal retreatment, limited to once per tooth, per lifetime
Treatment of root canal obstruction, no-surgical access
Incomplete endodontic therapy, inoperable or fractured tooth
Internal root repair of perforation defects

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

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Periodontal Services

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

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

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

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

Periodontal Surgery

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

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

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

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

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

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

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

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

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

Periodontal surgery related

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

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

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Surgical Extractions

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

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

Other Oral Surgical Procedures

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

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

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COORDINATION OF BENEFITS

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

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

Definitions

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

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

(1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.

(2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.

(3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.

(4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Order Of Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Effect On The Benefits Of This Plan

When This Plan Is Primary

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

When This Plan Is Secondary

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

WORKER'S COMPENSATION

For Persons Not Covered By Worker's Compensation

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

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

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

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

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

CGP-3-R-WCOMP-85 B595.0004

CERTIFICATE AMENDMENT

This rider amends this plan to include the following provision:

Right of Reimbursement

If a covered person recovers expenses for sickness or injury that occurred due to the negligence of a third party, we have the right to first reimbursement for all medical, dental, or loss of earnings benefits we paid from any and all damages collected from the negligent third party for those same expenses whether by action at law, settlement, or compromise, by the covered person, the covered person's parents if the covered person is a minor, or the covered person's legal representative, as a result of that sickness or injury. We are to be furnished any information or assistance, and be provided any documents that we may reasonably require, in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability. As used here, "third party" means anyone, other than Guardian, the employer or the covered person.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

CGP-3-A-TBL-IL-07 B600.0011

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

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

CGP-3-GLOSS-90 B750.0664

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

CGP-3-GLOSS-90 B750.0665

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

CGP-3-GLOSS-90 B750.0666

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

CGP-3-GLOSS-90 B750.0667

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

CGP-3-GLOSS-90 B750.0668

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

CGP-3-GLOSS-90 B750.0669

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

CGP-3-GLOSS-90 B750.0670

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

CGP-3-GLOSS-90 B750.0671

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

CGP-3-GLOSS-90 B900.0003

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

CGP-3-GLOSS-90 B750.0015

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

CGP-3-GLOSS-90 B750.0672

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

CGP-3-GLOSS-90 B750.0006

Employer means GENESEO COMMUNITY UNIT SCHOOL DISTRICT 228 .

CGP-3-GLOSS-90 B900.0051

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

CGP-3-GLOSS-90 B900.0004

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 35 hours per week), at his *employer's* place of business.

CGP-3-GLOSS.1 B750.0230

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

CGP-3-GLOSS-90 B900.0006

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

CGP-3-GLOSS-90 B750.0673

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

CGP-3-GLOSS-90 B900.0008

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* it includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. This *plan* does not pay benefits for *orthodontic treatment.*

CGP-3-GLOSS-90 B750.0685

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

CGP-3-GLOSS-90 B750.0676

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

CGP-3-GLOSS-90 B750.0677

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

CGP-3-GLOSS-90 B750.0679

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

CGP-3-GLOSS-90 B750.0678

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

CGP-3-GLOSS-90 B750.0681

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

CGP-3-GLOSS-90 B750.0682

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

CGP-3-GLOSS-90 B750.0683

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

The Guardian's Responsibilities

B800.0048

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

B800.0053

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

B800.0049

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

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0076

Termination of This Group Plan

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

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

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

B800.0007

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Effective: 5/01/2016

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.guardianlife.com/privacy-policy.

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and long term care coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes :

Treatment.Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment.Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations.Guardian may use and disclose your PHI to perform health care operations, such as administrative or business functions. For example, we may use your PHI for underwriting and premium rating purposes. However, we will not use or disclose your genetic information for underwriting purposes and are prohibited by law from doing so.

Appointment Reminders.Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services.Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.

Plan Sponsors.Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

B998.0051

Guardian is required to use or disclose your PHI :

- To you or your personal representative (someone with the legal right to make health care decisions for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action related to health information privacy or security; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your Unsecured PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. Under federal medical privacy law, a breach means the acquisition, access, use, or disclosure of unsecured PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures .

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care or payment for care, such as a family member or close personal friend, when you are present and do not object, when you incapacitated, under certain circumstances during an emergency or when otherwise permitted by law.
- We may use or disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may use or disclose your PHI in an emergency, directly to or through a disaster relief entity, to find and tell those close to you of your location or condition
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may use or disclose your PHI in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use disclose your PHI to comply with workers' compensation and other similar programs.

- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

B998.0052

We generally will not sell your PHI, or use or disclose PHI about you for marketing purposes without your authorization unless otherwise permitted by law.

Your Rights with Regard to Your Protected Health Information (PHI):

Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclosure your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, or (ii) you were required to give us your authorization as a condition of obtaining coverage, and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and /or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures . An 'accounting of disclosures' is a list of certain disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing by completing our form. Your request may state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list (e.g., paper, electronically). Our form for Account of Disclosure requests is available at www.guardianlife.com/privacy-policy.

Your Right to Obtain a Paper Copy of This Notice . You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically. You may obtain a paper copy of this notice by sending a request to the contact information listed at the end of this notice.

Your Right to File a Complaint . If you believe your privacy rights have been violated, you may file a complaint with Guardian or the Secretary of U.S. Department of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Please submit any exercise of the Rights designated below to Guardian in writing using the contact information listed below. For some requests, Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.

Your Right to Request Restrictions . You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian's use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications . You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

B998.0053

Your Right to Amend Your PHI . If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it (ii) if we do not maintain the PHI at issue (iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:
Guardian Corporate Privacy Officer
National Operations

Address:
The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 981573
El Paso, TX 79998-1573

B998.0055

CERTIFICATE OF COVERAGE

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

The Group Vision Insurance Coverage described in this Certificate is attached to the group Policy effective January 1, 2025. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Employer by Guardian.

GROUP VISION 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 Employer's eligibility and Effective Date requirements; (b) be listed in Our and/or the Employer'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 Certificate for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Employer's records.

Employer: GENESEO COMMUNITY UNIT SCHOOL DISTRICT 228

Group Policy Number: 00410242

Effective Date: January 1, 2025

Michael Prestileo,
Senior Vice President

Harris Oliner, Senior Vice President
and Corporate Secretary

B435.0959

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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.

Grace Period

A grace period, as stated in the Policy, without interest charge will be allowed for each premium payment except the first. If any premium with respect to a Covered Person is not paid before the end of the grace period, the Policy and this Certificate ends with respect to all Covered Persons at the end of the grace period. If the Policyholder gives Us advance written notice of an earlier termination date during the grace period, the Policy and this Certificate will end as of such earlier date.

If the Policy and this Certificate ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy and this Certificate was in force during the grace period.

Reinstatement

If the Policy lapses, the Policyholder may reinstate it within the prescribed number of days following the Policy lapse as stated in the Policy. Our acceptance of a premium payment without requiring an application for reinstatement will reinstate the Policy and this Certificate.

Assignment

No provision of the Illinois Insurance Code, or any other law, prohibits a Covered Person from making an assignment of all or any part of his/her rights and privileges under the Policy and this Certificate.

B435.1392

CONDITIONS OF ELIGIBILITY FOR GROUP VISION INSURANCE COVERAGE

B435.0005

Employee Eligibility

You are eligible for vision 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 vision 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.

Enrollment: If You must pay all or part of the cost of Employee coverage, You must enroll and agree to make required payments within 31 days of Your eligibility date. If You fail to do this, You cannot enroll until the plan's next vision open Enrollment Period. "Open Enrollment period" means an annual open enrollment period set up by the Employer and agreed to by Us.

This plan's vision open Enrollment Period occurs from December 1st to December 31st of each year.

Once You enroll in this plan, You cannot drop Your or Your dependent's vision coverage until this plan's next vision open Enrollment Period. Once You drop Your or Your dependent's vision coverage, You will not be permitted to enroll again until the next vision open Enrollment Period which starts after the date coverage is dropped.

If You initially waived vision coverage under this plan because You were covered under another group vision care plan, and You wish to enroll in this plan because Your coverage under the other plan ended, You may do so without waiting until the next vision open Enrollment Period. But, Your coverage under the other plan must have ended due to one of the events listed below:

- Termination of Your Spouse's employment.

- Loss of eligibility under Your Spouse's vision plan.
- Divorce.
- Death of Your Spouse.
- Termination of the other vision plan.

In that case, You must enroll in the vision coverage under this plan within 30 days of the date that any of the events listed above occurs.

B435.0970

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
  - A newborn child from the moment of birth, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
  - A former member of the military under age 30 who served as a member of the active or reserve components of any of the branches of the Armed Forces of the United States, provided he/she is an Illinois resident and has received a release or discharge other than a dishonorable discharge. The dependent must submit a form approved by the Illinois Department of Veterans' Affairs stating the date on which he/she was released from service in order to be considered an eligible dependent beyond the age limit established above for other dependent children; and
  - A child who is incapable of self-support because of a physical or mental incapacity. 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

- You send Us written proof, and We approve such 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.

Eligible dependent does not include anyone who is insured under the Policy as the Employee.

B435.2723

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

When Coverage Starts

Your Employer will inform You of Your Effective Date under the Group Vision Policy. Your coverage begins on the date:

- You and Your eligible dependents are eligible for the Group Vision Policy as stated in the Conditions Of Eligibility for Group Vision Insurance section; and
- You and Your eligible dependents have enrolled in the Group Vision Policy; and
- Required premiums have been paid.

B435.0036

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

Family Status Change

You may request the addition of Vision 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 the addition of Vision Insurance Coverage for which You were not previously insured. You must provide proof of the Family Status Change and request the addition of Vision Insurance Coverage in writing within 31 days after the date of the Family Status Change as described above.

Refer to the When Coverage Starts section for information regarding when this coverage is effective.

B435.0981

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.

B435.0536

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

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 vision coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group vision 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 vision coverage under the 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 vision 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.

B435.0038

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Dependent College Students - Medical Leave of Absence

A full-time college student that takes a medical leave of absence or reduces his/her course load to part-time status due to a catastrophic illness or injury shall qualify for continued dependent coverage. This continued dependent coverage shall end at the earlier of: 12 months after notice of said illness or injury; or when the coverage would have otherwise ended in accordance with the terms of this Certificate for reason(s) other than the change in full-time student status.

To qualify for this continued dependent coverage, the need for the medical leave of absence or part-time status must be supported by a clinical certification of need from a duly-licensed physician.

B435.0372

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 vision 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.

B435.0040

You may visit any provider. After Davis Vision pays its portion of the covered charges, You are responsible for the rest. This includes any Deductible, Copayment, and amounts above any coverage maximum, as well as, any remaining charges up to the provider's total charge for services received.

Your reimbursement will be based on Davis Vision's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

B435.1186

Filing A Claim

If You have services performed by a Preferred Provider, Your claim will be submitted for You and the payment will be sent directly to Your Preferred Provider.

If You have services performed by a Non-Preferred Provider, You will need to submit Your own claim.

Administration: We have the responsibility to fairly, thoroughly, objectively and timely investigate, evaluate and determine a Covered Person's eligibility for benefits under this Certificate. 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 Proof of Loss.
- Consider and interpret the terms of this Certificate 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 Certificate and applicable 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: You must send Us written notice for which a claim is being made within 20 days of the service. We will not void or reduce Your claim if You cannot send Us notice of claim within the required time. In that case, You must send Us notice of claim as soon as reasonably possible. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown. Notice given by or on behalf of the Covered Person or the beneficiary to the Guardian Life Insurance Company of America, or to any authorized agent of the company, with information sufficient to identify the Covered Person, shall be deemed notice to the company.

Claim Forms: We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, You will be considered to have complied with the requirements of the Certificate as to proof of loss and We will accept a written description and adequate proof of the service that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

Proof Of Loss: You must send written proof of loss to Our designated office within 90 days of the loss. We will not void or reduce Your claim if You cannot send Us proof of loss within the required time. In that case, You must send Us proof as soon as reasonably possible. However, under no circumstances will We pay benefits if written proof of loss is delayed for more than one year, unless You are unable to provide proof of loss because You are not legally competent or You lack legal capacity.

Payment Of Benefits: We will pay Vision benefits immediately upon receipt of due written proof of loss, subject to all the terms and conditions of this Policy. Failure to pay within such period shall entitle You to interest at the rate of 9 percent per annum from the 30th day after receipt of such proof of loss to the date of late payment, provided that interest amounting to less than one dollar need not be paid.

Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living. If You are not living and no beneficiary designation has been made, We have the right to pay all Vision benefits to one of the following:

Your

- Estate;
- Spouse;
- Parents;
- Children; or
- Brothers and sisters.

All claims must be sent to Davis Vision within one year of the date services are completed or supplies are received. To obtain a claim form visit Our website at www.guardianlife.com.

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

The Guardian Life Insurance Company of America
Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110-1525

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 3 years from the date of the final benefit determination.

Workers' Compensation: The Vision benefits provided by this Certificate are not in place of and do not affect requirements for coverage by Workers' Compensation.

B435.1396

VISION EXPENSE BENEFITS

This coverage will pay many of a Covered Person's vision care expenses. We pay benefits for Covered Charges incurred by a Covered Person. What We pay and the terms for payment are explained below.

This Certificate includes the Schedule(s) of Benefits. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

B435.0043

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

The Policy is designed to provide high quality vision care while controlling the cost of such care. To do this, the Policy encourages a Covered Person to seek vision care from vision care practitioners and vision care facilities that belong to Davis Vision, a vision care Preferred Provider Organization (PPO).

The vision care PPO is made up of Preferred Providers in a Covered Person's geographic area. When a Covered Person is enrolled in the Policy, he or she will get an enrollment packet. The packet will: (1) explain how to obtain benefits; and (2) contain information about current vision care Preferred Providers. He or she will also receive information on how to obtain a list of Davis Vision Preferred Providers in his or her area.

A Covered Person may receive vision services from any Davis Vision Preferred Provider. If a Preferred Provider ends his or her relationship with Davis Vision for any reason, Davis Vision will be responsible for furnishing vision services to Covered Persons either through that provider or another Davis Vision Preferred Provider.

Use of the vision care PPO is voluntary. A Covered Person may receive vision care from any vision care provider he or she chooses. And he or she is free to change providers at any time. But, the Policy usually pays more in benefits for covered services furnished by a Preferred Provider. Conversely, it usually pays less for covered services not furnished by a vision care Preferred Provider.

What We pay is based on all of the terms of the Policy. Please read this Certificate carefully for specific benefit levels, Copayments, Deductibles, Payment Rates and Payment Limits.

A Covered Person may call Davis Vision should he or she have any questions about the vision coverage.

Davis Vision's Customer Service

800-999-5431

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Obtaining Services from a Preferred Provider

When a Covered Person wishes to receive services from a Preferred Provider, he or she must contact the Preferred Provider before receiving the services. The Preferred Provider will contact Davis Vision to verify the Covered Person's coverage.

What We pay for charges for covered services is subject to all of the terms of this Certificate.

B435.0990

How This Plan Works

We pay benefits for the covered charges a Covered Person incurs as shown below. The services and supplies covered under this Certificate are explained in Covered Services and Supplies. What We pay is subject to all of the terms of this Certificate. Read the entire Certificate to find out what We limit or exclude.

Covered charges are the Usual and Customary charges for the services and supplies described below. We pay benefits only for covered charges Incurred by a Covered Person while he or she is covered by this Certificate. Charges in excess of any Payment Limits shown in this Certificate are not covered.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive authorization from Davis Vision. See Obtaining Services from a Preferred Provider.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to Davis Vision for claims payment. Please refer to Vision Claim Provisions in this Certificate.

Copayments: A Covered Person must pay a Copayment each time he or she receives a vision examination. And, he or she must pay a Copayment each time he or she receives lenses or a frame or a complete pair of eyeglasses covered by this Certificate. We pay benefits for the covered charges a Covered Person incurs in excess of the Copayment. This Certificate's Copayments are shown in the Schedule of Benefits.

Cash Deductibles: There are separate cash Deductibles for each covered service furnished by a Non-Preferred Provider. These cash Deductibles are shown in the Schedule of Benefits. The Covered person must have covered charges in excess of the cash Deductible before We pay benefits for the service or supply. The cash Deductible will be subtracted from the reimbursement to the member.

Payment Limits: Payment Limits, durational or monetary, are shown in Covered Services and Supplies. When a monetary Payment Limit is set for a pair of materials, the limit is halved if only one item is purchased.

Payment Rates: Once a Covered Person has paid any applicable Copayment or Deductible, We pay benefits for covered charges under this Certificate at the Payment Rate shown in the Schedule of Benefits. What We pay is subject to all of the terms of this Certificate.

B435.1030

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 Certificate. Read the entire Certificate to find out what We limit or exclude.

B435.0048

Vision Examinations: We cover charges for comprehensive vision care examinations of visual functions and prescription of corrective eyewear. We only cover charges for one vision examination for each Covered Person in any one calendar year Benefit Period. The comprehensive vision care examination does not include a contact lens exam (evaluation and fitting).

If a Covered Person receives a vision examination from a Preferred Provider, We pay benefits in full for the covered charges for that examination.

If a Covered Person receives a vision examination from a Non-Preferred Provider, We pay benefits for the covered charges for that examination, up to $50.00.

B435.0049

Vision Materials We cover charges for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We cover charges for frames. And, We cover charges for prescription contact lenses. Benefit allowances provide no remaining balance for future use within the same Benefit Period.

In any one calendar year Benefit Period We cover charges for either glasses or contact lenses, but not both.

B435.1189

Standard Lenses: We cover charges for single vision, bifocal, trifocal or Lenticular Lenses. They must be glass or plastic lenses or for dependent children to age 19, for monocular individuals and Covered Persons with prescriptions of > +/- 6.00 diopters, Polycarbonate Lenses.

B435.1038

We only cover charges for one pair of Standard Lenses in any one calendar year Benefit Period.

B435.0187

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) $48.00 for each pair of single vision lenses; (2) $67.00 for each pair of bifocal lenses; (3) $86.00 for each pair of trifocal lenses; and (4) $126.00 for each pair of Lenticular Lenses.

B435.0057

We pay the following benefits in full when a Covered Person purchases lenses from a Preferred provider:

- Scratch Resistant Coating
- Oversize Lenses
- Fashion and Gradient Tinting of Plastic Lenses

B435.1040

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 $150.00 for a non-collection frame. Most Preferred Providers discount any amount over the allowance by 20%. Discounts may not be available at all locations, check with Your Preferred Provider.

If a Preferred Provider offers Davis Vision's exclusive frame collection, We pay benefits for covered charges for any fashion or designer collection frame in full. And, We pay benefits for covered charges for any premier collection frame selected in full in excess of an additional $25.00 Copayment.

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for a set of Standard Frames to $48.00.

We only cover charges for one set of Standard Frames in any 2 calendar Year period.

B435.1198

Necessary Contact Lenses: We cover charges for necessary contact lenses but only in place of all other lens and frame benefits available herein. This means that utilization of contact lens benefits exhausts all of the Covered Person's lens and frame benefits for the current Benefit Period, and future eligibility for lenses and frames will be determined as if spectacle lenses and frames were obtained in the current Benefit Period. We cover necessary contact lenses and charges for related professional services when a Preferred Provider obtains prior approval from Davis Vision but only if the lenses are needed: (1) following cataract surgery; (2) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; (3) for certain conditions of: Anisometropia; Aniseikonia; Keratoconus; Irregular Astigmatism; Corneal Disorders; Aphakia; Aniridia; or High Myopia.

And, We only cover charges for one pair of necessary contact lenses in any one calendar year Benefit Period.

If a Covered Person receives necessary contact lenses from a Preferred Provider, We pay 100% of the covered charges.

If a Covered Person receives necessary contact lenses from a Non-Preferred Provider, We limit what We pay for covered charges for such lenses to $210.00 in any one calendar year Benefit Period.

B435.1079

Elective Contact Lenses: We cover charges for elective contact lenses. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective contact lenses.

If the Covered Person chooses elective contact lenses, We do not cover charges for Standard Lenses for one calendar year from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for non-Collection elective contact lenses to $150.00. Most Preferred Providers will discount any amount over the allowance by 15%. Discounts may not be available at all locations, check with Your Preferred Provider. Covered Persons must obtain all the elective contact lenses available within the Benefit Period at the same time. Any amounts remaining cannot be banked for future use.

If a Preferred Provider offers Davis Vision's elective contact lenses collection, We pay benefits for covered charges for any elective contact lenses selected from the collection in excess of the Copayment, if any. We cover two boxes of planned replacement or four boxes of disposable elective contact lenses. Contact lens fitting and evaluation (contact lens exam) is included at no additional cost only when collection contacts are purchased. The collection is not available at retail locations.

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for elective contact lenses to $105.00.

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

Charges are covered up to the contact lens allowance. The allowance may be applied towards an elective contact lens Fitting and Evaluation at some provider locations.

B435.1086

Low Vision Benefits: We pay benefits for the covered charges at the Payment Rates shown in the Schedule of Benefits provided to a Covered Person who has severe visual problems which cannot be corrected with Standard Lenses.

Low Vision services are Low Vision Supplementary Testing and Low Vision Supplemental Care.

If a Covered Person receives Low Vision Supplementary Testing, We pay benefits for the covered charges for the testing up to $300.00 per test.

We cover no more than one Low Vision Supplementary Test(s) per Covered Person in any 5 year Period.

We cover services for Low Vision Aid devices up to $600.00 in any one calendar year Period with a lifetime maximum of $1,200.00.

We cover services for four follow up care visits in any 5 year period up to $100.00 per visit.

B435.1125

Exclusions

No benefits will be paid for services or materials connected with, or charges arising from:

- Orthoptics or vision training and any associated supplemental testing.
- Aniseikonic lenses.
- Medical and/or surgical treatment of the eyes or supporting structures.
- Any vision examination or corrective eyewear or safety eyewear required by an employer as a condition of employment unless specifically covered under this Certificate.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof.
- Services or materials provided by any other group benefit plan providing vision care.
- Plano Lenses (non-prescription lenses with less than a +/- .50 diopter power).
- Plano contact lenses to change eye color cosmetically or artistically painted contact lenses.
- Non-prescription sunglasses.
- Two sets of glasses in lieu of bifocals.
- Replacement of lenses, frames, glasses or contact lenses furnished under this Certificate which are lost or broken, except at normal intervals when services are otherwise available.
- Refitting of contact lenses after the initial 90 day fitting period.
- Routine maintenance of contact lenses, such as polishing or cleaning or modifications to contact lenses.
- Corneal refractive therapy (CRT) or orthokeratology (using contact lenses to change the shape of the cornea to reduce myopia).
- A frame that costs more than this Certificate allowance.
- Unused allowance amounts cannot be banked for future use. The allowance must be used during the same office visit.

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- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.
- Blended Lenses
- Progressive Multi-Focal Lenses
- Polycarbonate Lenses for adults
- High Index Lenses
- Anti-Reflective Coating of the lens or lenses
- Polarized/Laminated Lenses
- Ultraviolet Coating of Lenses
- Transition Lenses
- Photochromic Lenses
- Mirror and Ski Coating
- Edge Treatment

Charges not covered due to these exclusions are not considered charges for covered vision services and cannot be used to satisfy this Certificate's Copayments or Deductibles, if any.

B435.1128

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

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.

B435.0102

Aniridia: This term means the absence of the iris in the eye, occurring congenitally or as a result of trauma or surgery.

B435.1042

Aniseikonia: This term means a condition that results from an excessive difference in the prescription between the eyes. This causes a difference in image size perceived between the eyes from unequal magnification, and can manifest with symptoms of headache, dizziness, disorientation, and excessive eye strain.

B435.1043

Anisometropia: This term means a condition in which two eyes have unequal refractive power. Each eye can be nearsighted (myopia), farsighted (hyperopia), or a combination of both, which is called antimetropia. Generally a difference in power of two diopters or more is the accepted threshold to label the condition anisometropia.

B435.1044

Anti-Reflective Coating: This term means a clear lens coating that limits light reflection by allowing the maximum amount of light to pass through the lens.

B435.0105

Aphakia: This term means the absence of the lens of an eye, occurring congenitally or as a result of trauma or surgery without implantation of an intraocular lens.

B435.0106

Benefit Period: This term means the time period beginning when a covered service is received and extending for the period shown in this Certificate, during which benefits for the covered service are available to a Covered Person.

B040.0846

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

B040.0847

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.

B435.0108

Copayment: This term 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 services are received.

B435.0109

Corneal Disorders: This term means any condition (other than Keratoconus) of congenital, pathological or surgical etiology causing compromised integrity of the corneal curvature or media resulting in best correctable acuity of 20/70 or less with spectacles in one or both eyes.

B435.0110

Covered Person: This term means You, if You are covered by the Policy, and any of Your covered dependents.

B435.0185

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.

B435.0111

Edge Treatment: This term means a cosmetic service to make the sides of a cut lens look clear rather than a milky white.

B435.0112

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.

B435.0113

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.

B435.0114

Employee: This term means the member of the group determined to be eligible by the Employer.

B435.0115

Employer: This term means the entity that purchased the Policy.

B435.0116

Enrollment Period: This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B040.0856

Fashion and Gradient Tinting of Plastic Lenses: This term means lenses which have an additional substance added to produce constant tint or coating that is darker at the top of the lens, fading to lighter at the bottom.

B435.1045

Fitting and Evaluation: This term means an examination for the proper fit of contacts and evaluating vision with the contacts. Includes prescription, fitting, evaluation, modification and/or dispensing of contact lenses.

B435.0117

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 Employer in Your Eligible class (but not less than 35 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.

B435.0146

High Index Lenses: This term means material that is used to create thinner lenses than normal plastic. The material does not contain the impact-resistant qualities of polycarbonate.

B435.0120

High Myopia: Refractive error greater than plus or minus 10.00 diopters of correction; best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with contact lenses.

B435.0121

Incurred, or Incurred Date: These terms mean: (1) the placing of an order for lenses, frames or contact lenses; or (2) the date on which such an order was placed.

B040.0860

Irregular Astigmatism: This term means greater than or equal to 2.00 diopters of astigmatism in either eye where the principal meridians are separated by less than 90 degrees, resulting in best correctable acuity of 20/70 or less in the affected eye with spectacles.

B435.0123

Keratoconus: This term means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area. Diagnosis confirmed by keratometric readings, or corneal topography best correctable visual acuity with spectacles of 20/40 or less in either eye; at least two lines improvement in best correctable visual acuity (as measured with standard Snellen chart) with rigid contact lenses.

B435.0124

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

B040.0862

Low Vision: This term means a partial loss of vision; a loss of acuity or sharpness or a loss of side/peripheral vision; and that the Covered Person's most favorable corrected visual acuity is 20/70 or worse in one or both eyes.

B435.1046

Low Vision Supplemental Care: This term means subsequent Low Vision therapy, when visually necessary or appropriate.

B435.1047

Low Vision Supplementary Testing: This term means a Low Vision analysis and diagnosis. The analysis and diagnosis includes: (a) a comprehensive examination of visual functions; and (b) the prescription of corrective eyewear or vision aids, when required.

B435.1048

Mirror and Ski Coating: This term means a thin deposit of appropriate material to the front surface of a lens, causing a portion of the light striking the lens to reflect directly from the front surface.

B435.0125

Non-Preferred Provider: This term means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider that is not under contract with Davis Vision as a Preferred Provider.

B435.1403

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

B040.0865

Oversize Lenses: This term means larger than a standard lens blank, to accommodate prescriptions.

B040.0866

Payment Limit: This term means the maximum amount this Certificate pays for covered services and supplies during a specified Benefit Period.

B435.0128

Payment Rate: This term means the percentage rate that this Certificate pays for covered services and supplies.

B435.0129

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

B040.0870

Plano Lenses: This term means lenses which have no refractive power (lenses with less than a greater than or equal to .38 diopter power).

B435.0130

Polarized/Laminated Lenses: This term means lenses that block light reflected from horizontal surfaces such as water, in order to reduce glare.

B435.0131

Policy: This term means the group Vision Insurance Coverage described in the Policy and this Certificate.

B435.0132

Polycarbonate Lenses: This term means the highest impact-resistant lens material available. Its high-index properties result in lenses 20-25% thinner than regular plastic. This material is often used for safety and children's eyewear as well as for sports and cosmetic purposes.

B435.0133

Preferred Provider: This term means an optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and or Vision Materials to Covered Persons.

B435.1406

Progressive Multi-Focal Lenses: This term means lenses that have no line, but progresses from distance, to intermediate, to near vision.

B435.0135

Registered Reciprocal Beneficiaries: This term means an employee and his or her reciprocal beneficiary: (a) who have filed a Declaration of Reciprocal Beneficiary Relationship with the Director of Health of the State of Hawaii as provided in section 572C-5 of the Hawaii Revised Statutes; (b) the declaration has been registered by the Director; and (c) a certificate of reciprocal beneficiary relationship has been provided to each party named on the declaration.

B435.1984

Reciprocal Beneficiary: This term means an adult who is a party to a valid reciprocal beneficiary relationship and who meets the following requirements for such a relationship:

- Each of the parties must be at least eighteen years old.
- Neither of the parties can be married nor a party to another reciprocal beneficiary relationship.

- The parties must be legally prohibited from marrying one another under chapter 572 of the Hawaii Revised Statutes.
- Consent of either party to the reciprocal beneficiary relationship has not been obtained by force, duress, or fraud.
- Each of the parties must sign a Declaration of Reciprocal Beneficiary Relationship.

B435.1985

Scratch Resistant Coating: This term means a coating applied to spectacle lenses to increase the scratch resistance of the lens surface.

B435.0136

Spouse: This term, which includes Your same-sex or opposite-sex civil union partner, means the person to whom You are legally married, as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or civil union was recorded. Illinois allows both same sex and different sex couples to enter into a civil union, with all of the obligations, protections and legal rights that Illinois provides to married heterosexual couples.

B435.1409

Standard Frames: This term means frames valued up to the limit published by Davis Vision which is given to Preferred Providers.

B435.1051

Standard Lenses: This term means regular glass or plastic lenses.

B435.0139

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

B040.0878

Transition Lenses: This term means plastic lenses that turn dark when exposed to the ultraviolet rays of the sun.

B435.0140

Ultraviolet Coating (UV): This term means a coating that blocks ultraviolet rays.

B435.0141

Usual And Customary: This term means that the charge for the covered vision condition: (1) is the provider's standard charge for the service furnished; and (2) is not more than the usual charge made by most other providers with similar training and experience in the same geographic area. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

B040.0879

Vision Materials: This term means (1) Elective Contact Lenses; or (2) Standard Lenses, Standard Frames or a complete pair of eyeglasses (lenses and frames).

B435.0142

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

B435.0143

You, Your or Your: These terms mean the covered Employee.

B435.0144

STATEMENT OF ERISA RIGHTS

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

Your group Vision 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 benefit is denied or ignored, or partially denied or ignored, 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, or partially denied or ignored, 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 required that group health plans provide medical coverage for a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Vision 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.

Vision 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.

B435.0375

Definitions

"Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment 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 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 Benefit Determination nor that person's subordinate;
- In deciding an appeal based upon a vision 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 vision or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;

- 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.

B435.0376

VISION 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.

B435.1131

Initial Election

You may choose to be covered under one of the plans of vision expense coverage offered by Your Employer. You may only be covered under one plan at a time. You must notify the Employer of Your election and pay the required premium.

B435.0151

Group Enrollment Period

A group enrollment period is held each year from December 1st to December 31st. During this period, You may choose to enroll for vision insurance coverage under the Policy. In that case, coverage is scheduled to start on the date determined by Your Employer that next follows the date You enroll.

B435.0155

PPO Copayments

Examinations	$10.00
Standard Frames and/or Standard Lenses	$25.00
Premier Collection Frame	$25.00
Designer Collection Frame	None
Fashion Collection Frame	None
Low Vision Examinations and Services	None
Low Vision Materials	None

Non-PPO Cash Deductibles

Examinations	$10.00
Standard Frames and/or Standard Lenses	$25.00
Low Vision Examinations and Services	None
Low Vision Materials	None

Payment Rates

For Covered Charges	100%

Covered Services And Supplies Allowances

Vision Examinations furnished by a Preferred Provider	Covered In Full
Vision Examinations furnished by a Non-Preferred Provider	$50.00
Standard Frames furnished by a Preferred Provider	$150.00
Standard Frames furnished by a Non-Preferred Provider	$48.00
Necessary Contact Lenses furnished by a Preferred Provider	Covered In Full
Necessary Contact Lenses furnished by a Non-Preferred Provider	$210.00
Elective Contact Lenses furnished by a Preferred Provider	$150.00
Elective Contact Lenses furnished by a Non-Preferred Provider	$105.00

Standard Lenses furnished by a Preferred Provider . . . . . Covered In Full
Standard Lenses single vision furnished by a Non-Preferred Provider $48.00
Standard Lenses bifocal furnished by a Non-Preferred Provider $67.00
Standard Lenses trifocal furnished by a Non-Preferred Provider $86.00
Standard Lenses lenticular furnished by a Non-Preferred Provider $126.00

Low Vision Supplementary Testing from a Preferred Provider $300.00
Low Vision Supplementary Testing from a Non-Preferred Provider $300.00
All Low Vision Services Maximum Benefit $1200.00
Low Vision Aid Devices $600.00
Low Vision follow-up Care visits $100.00

Standard Frame overage 20%

Contact Lens overage 15%

Changes in Coverage 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 until the date You return to Active Work on a Full-Time basis.

Changes In Insurance Classification

If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the amount within 31 days of the change.

B435.1139

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**

B101.0002

Guardian

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, New York 10001

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