
**YOUR
GROUP INSURANCE
PLAN**

**SAINT FRANCIS HIGH SCHOOL
CLASS 0001
DENTAL, VISION**

The Guardian Life Insurance Company of America

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM

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All Options

Important Notices

Employer-funded benefits - not insured by Guardian

This Member Guide explains the coverage your planholder offers. It explains the benefits available, as well as the requirements and limits of this coverage.

This is not insurance provided by Guardian. Instead, your planholder has engaged Guardian only to provide administrative services, such as processing claims. Your planholder's funds will be used to pay these claims. Your planholder is solely responsible and liable for the benefits available under this Plan.

You may not be covered by all of the options in this Member Guide

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



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

Dental insurance member guide

Welcome to Guardian!

We've been selected by your organization to provide group dental insurance. We'd like to welcome you to our company!

This is the member guide

This guide explains how this insurance coverage works and gives important details about the coverage.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-627-4200

guardianlife.com

Planholder: SAINT FRANCIS HIGH SCHOOL

Plan Number: 00051756

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All Options

Guide basics

This Member Guide is part of a group insurance Plan

We've entered into an agreement with the Planholder listed on the first page to provide this insurance coverage. The details of the agreement are contained in the Policy we've issued to the Planholder. Check with your Planholder to determine if this coverage is available to you.

This Member Guide is part of the Policy we've issued to the Planholder. Although this is considered a certificate of insurance, we usually refer to this simply as the guide. This guide is important because it tells you how this insurance coverage works.

Unless we specifically say otherwise, when we mention "you" and "your" in this guide, we're referring to you, a member of the organization listed on the first page as the Planholder. Where we say "we" and "us", we're referring to The Guardian Life Insurance Company of America. We usually refer to ourselves simply as Guardian.

How this guide is organized

This guide has five sections. Here's what you'll find in each section:

- **Your benefits**
This section explains the benefit options that are available to you. This section will help you understand the details of your coverage and how much we'll pay when you receive dental care.
- **Using your benefits**
This is where you'll find how benefits are paid and how you or your dentist can submit a claim for benefits.
- **Member coverage & family coverage**
Here's where we explain who's eligible for this coverage and what you need to do to obtain coverage. We also explain what can end your eligibility for coverage.
- **Other things you should know**
You should review and understand these other items that are also important to your coverage.
- **Covered Services Guide**
This may be a separate document but is considered part of this guide. It lists the different dental services covered by this guide and explains any limits or requirements you need to know.

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All Options

Your benefits

This section explains the benefits available through this guide, including:

- Dental services that are covered
- How much we'll pay
- Any deductibles and benefit maximums

When we mention family and family members in this section, we're referring to family members who are covered by this guide.

This guide uses the term "benefit year". This is the 12-month period that begins on January 1st and ends on December 31st.

Covered dental services

There are many different dental services you can receive from your dentist. The services for which benefits are available are grouped into one of the categories listed below. These categories will help you understand what we'll pay, as well as any deductibles that must be met.

This list is a summary. For a detailed list of covered services, and the requirements or limits that apply to them, see the Covered Services Guide.

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All Options

What we pay

Preventive services

- In-network dentist 100%
- Out of network dentist 100%

All Options

Basic services

- In-network dentist 80%
- Out of network dentist 80%

All Options

Major services

- In-network dentist 50%
- Out of network dentist 50%

All Options

Orthodontic care

- In-network dentist 50%
- Out of network dentist 50%

All Options

Using a network dentist can save you money

We have a network of dentists to help lower your dental expenses. Our network is called DentalGuard Preferred.

You can go to any dentist you choose, but you can save money by using a dentist in our network. Even though the percentage we'll pay is the same for any dentist, the dentists in our network will discount their fees for many services. As a result, any amount you're responsible for paying may be less when you use a dentist in our network. This could mean lower out-of-pocket costs for you.

Some states allow dentists in our network to charge the full, undiscounted amount for dental services that aren't covered by this guide. This means if your dentist provides a service that isn't covered by this guide, you won't receive any benefits and you might not receive a discount.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice.

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All Options

What happens when you use a dentist that isn't in our network

If you use a dentist that isn't in our network, the benefits we pay will be based on the lesser of:

- the dentist's fee
- the amount dentists in your local area typically charge for the same service

Your local area is the area represented by the first 3 digits of the zip code in which your dentist provided the service. The amount dentists typically charge for the same services means that 90% of the dentists charge this amount or less for the service. We determine this amount in accordance with Guardian's Reimbursement Schedule, which includes a combination of insurance market, third party and our own data.

We may pay benefits based on a less expensive alternative treatment or service. We'll do this when the lower cost service would be appropriate based on professionally accepted standards of dental practice. If this happens, we'll use the average cost of the alternative treatment or service in your local area to determine the benefits available.

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All Options

Deductibles

All Options

Annual deductible

- In-network dentist Doesn't apply
- Out of network dentist Doesn't apply

All Options

Deductible(s) satisfied under a prior plan

If this Plan replaced a prior plan, we'll give you credit for any portion of the annual deductible that had already been met for the same benefit year. Documentation of the expenses applied to the prior plan's deductible will be required.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

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All Options

Benefit maximums

A benefit maximum is the most we'll pay for dental services received during a specific period of time, such as a benefit year or during your lifetime on this Plan. Once we've paid this amount, no additional benefits will be available for services received during that period.

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All Options

Annual maximum

- In-network dentist \$2,000.00
- Out of network dentist \$2,000.00

All Options

Orthodontic lifetime maximum

- In-network dentist \$1,000.00
- Out of network dentist \$1,000.00

All Options

The annual maximum is the most we'll pay in benefits for dental services you receive during a benefit year. The annual maximum is listed in the table above.

This maximum applies to you and each of your family members separately. This means you each have an annual maximum in the amount listed in the table above.

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All Options

Orthodontic care lifetime maximum

Orthodontic care has its own lifetime maximum. This is the most we'll pay in benefits for orthodontic care received during your lifetime on this Plan. The orthodontic care lifetime maximum is listed in the table above.

This maximum applies to each person that receives orthodontic care benefits separately. This means each person eligible to receive orthodontic care benefits has a lifetime maximum in the amount listed in the table above.

Benefits paid for orthodontic care will count toward the orthodontic care lifetime maximum, but not the annual maximum for other services listed above.

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All Options

In-network vs. out of network

The maximum benefits available may depend on the type of dentist you use. This is listed in the above table.

Benefits paid for services received from a DentalGuard Preferred dentist will also count toward the maximum amount available for services received from a dentist that isn't in our network. Similarly, any benefits paid for services received from a dentist that isn't in our network will also count toward the maximum amount available for services you receive from a DentalGuard Preferred dentist.

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All Options

Benefits paid under a prior plan

If this Plan replaced a prior plan, any benefits paid for dental services received during the same benefit year will be deducted from the annual maximum listed above. Documentation of benefits paid under the prior plan will be required.

Any benefits paid under a prior plan for orthodontic care will be deducted from this Plan's orthodontic care lifetime maximum.

A prior plan is the plan that your Planholder had immediately before this Plan. For it to be considered a prior plan, it must have ended the day before this Plan began.

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All Options

Waiting period if you enroll late

If you don't enroll for coverage within the time allowed benefits for some dental services won't be available until after you've met a waiting period. You won't receive any benefits for the following dental services if they're received during the waiting period listed:

Dental service

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All Options

- Basic services 6 months
- Major services 12 months
- Orthodontic services 24 months

The same waiting periods must be satisfied by each family member that's enrolled late.

The waiting periods listed above are in addition to any other waiting periods included under this Plan. This means the waiting periods for enrolling late will not begin until any other waiting period for the same dental service has been satisfied.

Dental services received within the waiting period won't be covered and can't be used to meet the deductible.

See the **You must enroll within the time allowed** section for more information.

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All Options

Using your benefits

Timely access to care

California law requires dental plans to provide timely access to care. This means that there are limits on how long you have to wait to get dental appointments and telephone advice.

- Urgent appointments - You have the right to an appointment within 72 hours.
- Non-urgent appointments - You have the right to:
 - A non-urgent appointment within 36 business days
 - Preventive care appointments within 40 business days

The wait time standards don't apply if you're requesting a specific date and time.

Continuity of care

If your dentist leaves our network while you're receiving covered services for an acute condition, we'll consider the completion of those services for that condition as being performed by an in network dentist.

At your request, we can arrange for the completion of covered services by the terminated dentist for the remainder of the acute condition. An acute condition means a dental condition that involves a sudden onset of symptoms that requires prompt attention and that has a limited duration. A terminated dentist means a dentist whose contract to provide services is terminated or not renewed by us or one of our contracting dental groups. You must be undergoing a course of treatment for an acute condition and your coverage under the policy must continue during the completion of covered services.

Paying your dentist

When you receive dental care, your dentist might submit your claim and wait to see what we pay before asking you to pay anything. Or your dentist could ask that you pay for the services at the time you receive them. Then, either you or your dentist can submit your claim for benefits under this Plan.

See the **What you should do when you have a claim** section for more information on how to send us your claim.

What you're responsible for paying

You're responsible for paying your dentist for any dental expenses that aren't covered by this guide. This includes any deductibles and any other amounts we don't pay. For example, if we pay 80% of a covered service, this means you must pay the other 20%. This is sometimes referred to as "coinsurance".

You're also responsible for paying any fees for services that exceed what's allowed by this guide.

If you use an in-network dentist, you don't need to pay any amounts that are over the discounted amount your dentist agreed to accept. See the **Using a network dentist can save you money** section for more information.

Pre-treatment review of proposed dental services

If you'd like to know how much we'll pay for a dental service before you receive it, we encourage you to have your dentist submit a pre-treatment review. We'll compare the services proposed to the benefits available under this guide and tell you how much we expect to pay. You'll then know how much of the dentist's fee you'll have to pay.

Although these reviews are completely optional, they're a good way to avoid surprises.

Please keep in mind, the amount we tell you we expect to pay is an estimate. The amount we'll pay when you receive the service can change because of factors such as the maximum benefits remaining, your dentist's participation in our network and you continuing to be covered under this Plan.

Your dentist can submit a pre-treatment review in the same way that a claim is submitted. If you have any questions on how to do this, contact your dentist or visit us at guardianlife.com.

Once you've received the proposed services, a claim will need to be submitted so we can pay any benefits available. See the **What you should do when you have a claim** section for more information.

What you should do when you have a claim

Your dentist might submit your claim for you. If your dentist doesn't submit your claim, you can do it yourself by following these simple steps:

Step 1 - Start your claim

When you have a claim, you'll need to complete a claim form. Part of the form will have to be filled out by your dentist. When it's complete, you or your dentist should send it to us.

You can print a claim form by going to guardianlife.com.

You can also call us at 800-541-7846 to request a claim form.

You can also write to us to tell us you have a claim. Our address for claims is:

Guardian

Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

If we don't send you a claim form within 15 days of when you asked for it, you can still submit your claim. To do so, mail us a copy of the dentist's bill. This should identify who you are and include the date(s) and details about the services received. Send this to the address listed above.

Step 2 - Submit your claim

If you're submitting a paper claim, the completed claim form should be mailed to:

Guardian

Group Dental Claims Department
P.O. Box 981572
El Paso, TX 79998-1572

Be sure to include all the information and copies of any documents the instructions indicate are necessary. The claim form and supporting documents are referred to as "proof of loss".

You or your dentist should submit your proof of loss as soon as you can, but you must submit it within 15 months of the date you received the dental services for which you're seeking benefits.

We'll only consider claims submitted after this 15 month period if you were legally incapacitated and unable to submit it within the time allowed.

What we'll do when we receive your claim

We'll review your claim to make sure it's complete

- We'll conduct a full and fair review of your claim.
- We'll complete our review of your claim within 30 days of receiving your proof of loss.

- In the event we need more time to consider your claim, which might be the case if we need more information, we can extend this review period by an additional 60 days. We'll notify you in writing if this happens and we'll explain the reason(s) more time is needed.
- If we need more information to consider your claim, we may request this information directly from your dentist. We may need to obtain X-rays, periodontal charting, narratives and other diagnostic information to consider your claim. Your dentist must provide us with the information we need to evaluate your treatment and determine the benefits payable.
- We may use the professional review of a dentist to determine the appropriate benefit for a dental service or course of treatment.
- If we need additional information from you, we'll let you know.

We'll determine if benefits are payable

- We'll make a decision within 30 days of our receiving the information needed to consider your claim.
- If benefits are payable, we'll pay the amount specified in this guide.
- If we deny any part of your claim, we'll provide a written explanation of the specific reason(s) your claim wasn't paid. We'll also include information on how you can appeal our decision.

When we'll pay

If we determine benefits are payable, they'll be paid promptly, and no more than 30 days from the date we receive the information needed to make the decision on your claim.

Who we'll pay

If an in-network dentist provided your dental services, we'll pay the benefits directly to your dentist.

If a dentist that isn't in our network provided your dental services, we'll pay the benefits to you unless you instruct us to pay your dentist directly.

If you're no longer living, we have the right to pay your benefits to one of the following, in the order listed:

- Your spouse
- Your children
- Your parents
- Your estate

If benefits are payable to your estate, and the amount is \$1,000 or less, we can pay someone related to you by blood or marriage who we believe is entitled to the benefits. Any such payment will meet our obligations under this Plan.

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All Options

What happens if your claim is denied

If we deny your claim or a part of your claim, we'll provide a written explanation within 30 days of our receiving the information we needed to make the decision. This explanation will include the specific reasons the claim was denied.

If we deny your claim because you or your dentist didn't reply to our requests for information, we'll provide a written explanation within 30 days of the date the information was due. This explanation will list the information you or your dentist were asked to submit.

We'll also provide instructions listing your rights to appeal your claim. These will explain the following:

- You'll need to submit a written appeal within 180 days of receiving our claims decision. The appeal should include any additional information or documentation you or your dentist think would be important for us to consider. Send your appeal to the address listed in the appeal instructions.
- We'll conduct a full and fair review of your appeal.
- We'll complete our review within 60 days of our receipt of your appeal.

- In the event we need more time to consider your appeal, which might happen if we need additional information, we can extend this review period by another 60 days. We'll let you know if additional time or information is needed.
- We'll let you know of our decision in writing. If we deny your appeal, we'll provide the specific reasons for the denial.

You should refer to the instructions included with any denial for more information on the appeals process.

What you can do if you have a complaint or grievance

If you have a complaint or grievance, you can call us at 800-541-7846 and we'll provide you with instructions on how to file your complaint or grievance.

You can also contact the California Department of Insurance:

Department of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1-800-927-HELP (4357)
TDD: 1-800-482-4TDD (4883)

Website: www.insurance.ca.gov/01-consumers/

Other things you should know about claims

Who pays first when you're covered by more than one plan

Because you and any family members covered by this Plan may have other dental coverage, we need to determine which plan is responsible for paying first. We coordinate benefits with other plans, so the total amount of benefits paid doesn't exceed the allowable amount for the services received.

This Plan will pay any benefits available for the covered services you receive before any other dental plan.

For covered services your spouse receives, the plan that will pay any benefits available first will be:

- Your spouse's plan if your spouse is covered as an active employee.
- The plan that's been in place the longest if the above rule doesn't apply.

For covered services your child receives, the plan that will pay any benefits available first will be:

- The plan of the parent whose birthday is earlier in the year.
- For a child whose parents are separated and not living together:
 - In an equal custody split, the plan of the parent whose birthday is earlier in the year.
 - The plan identified by any applicable court order.
 - If there isn't a court order that says which plan pays first, the dental services will be paid in the following order:
 - The plan of a biological parent with custody pays first.
 - The plan of a stepparent with custody pays second.
 - The plan of a biological parent without custody pays third.
 - The plan of a stepparent without custody pays fourth.

Coordinating benefits

When this Plan pays benefits first, we'll calculate the benefits payable as if you have no other dental coverage.

When another plan pays benefits first, the benefits available under this Plan will be calculated so that the total amount of benefits paid between all of your plans combined doesn't exceed the allowable amount for the services received. We also won't pay more in benefits than we'd pay if this Plan paid first.

A dentist that's in a network has agreed to charge a certain amount for specific dental services. These amounts are listed in what we call a fee schedule. We apply the following rules when determining the benefits available:

- When both plans use a fee schedule, the schedule allowing the higher fee will be used.
- When the plan that pays first is the only plan that uses a fee schedule, that plan's fee schedule will be used.
- When another plan pays first and doesn't use a fee schedule, the fee schedule for this Plan will be used.
- When neither plan uses a fee schedule, the highest allowable amount offered by either plan will be used.

Overpayments

If we paid more in benefits than this guide offers, you'll have to return the amount of the overpayment to us. We may ask you to send us the overpayment, or we might deduct the overpayment from future benefits.

Legal action

You can't bring a legal action under this Plan until 60 days after you've submitted proof of loss. You also can't bring a legal action more than three years from the time proof of loss is required, or the date we make a decision on your claim, whichever is later.

Examination

While we're reviewing your claim or appeal, we may require that you be examined by a medical or dental practitioner of our choice as often as reasonably necessary.

We'll pay for any examination we require.

Insurance fraud

We can terminate this coverage if you or your representative commits fraud with respect to a claim.

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All Options

Member coverage

Who's eligible

To be eligible for coverage under the Plan, you must meet the following requirements:

You must be in an eligible class of members

Your Planholder may choose to offer coverage to all members or only to those in certain job classifications.

A job classification or class of members is a group of members that fit into the same category. For example, a Planholder could have one class for hourly employees and another class for salaried employees.

If only certain classes are eligible for coverage, you must be in one of these classes to obtain coverage. If you have any questions about your eligibility, please contact your Planholder.

You must meet the minimum number of working hours required

You need to be actively working and performing the regular duties of your job. You must be working the number of hours your Planholder requires for your class, and not less than 20 hours per week.

You must wait to be eligible for coverage

Your Planholder has a waiting period that new members must meet before they can be eligible for this coverage. Your Planholder can tell you if you must meet a waiting period and how long it lasts.

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All Options

How to get coverage

If you meet the eligibility rules listed above, you must also do the following to obtain coverage:

You must enroll within the time allowed

You must enroll within 31 days of the date you first become eligible for coverage.

You can also enroll when you have a qualifying life event

If you don't enroll within the time allowed, you can enroll within 31 days of a qualifying life event. This includes:

- Your coverage ending under another dental plan
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- Your loss of coverage under your spouse's dental plan
- An event required by state or federal law or specified by your Planholder's guidelines

What happens if you enroll late

If you don't enroll within the time allowed, you'll be able to enroll during the next open enrollment period.

Enrollment periods usually occur once every year. We agree with your Planholder on when open enrollment periods happen, and how long they last.

If you have any questions about the open enrollment periods or when you can enroll, please contact your Planholder.

You may have to satisfy a waiting period if you enroll late. See the **Waiting period if you enroll late** section for more information.

Your premium must be paid

We must receive the required premium for your coverage.

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All Options

When your coverage begins

If you're eligible for coverage and have done what's required to obtain coverage, as explained under **How to get coverage**, your coverage begins at 12:01 AM EST on the first day you became eligible for coverage.

You must be actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on the date your coverage is scheduled to begin. If you don't meet this requirement, your coverage won't begin until you return to being actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder.

Your coverage may be scheduled to begin on or during one of the following:

- A holiday
- A vacation day
- A day you're not scheduled to work

If this happens, coverage will still begin on that same day if you were actively at work, performing the major duties of your regular job and working the required number of hours at the location required by your Planholder on your last regularly scheduled workday.

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All Options

When your coverage ends

Your coverage will end at 11:59 PM EST on the earliest of the following:

- The last day of the month in which you're no longer eligible under this guide.
- The date this coverage is no longer available to the class of members to which you belong.
- The last day of the period or which the required premiums have been paid.
- The day you die.
- The day this Plan ends.

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All Options

COBRA continuation rights

If your coverage ends, or a family member's coverage ends, you may be able to keep this coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, (COBRA). If you have any questions, please contact your Planholder or visit us at guardianlife.com.

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All Options

Family leave of absence - Family & Medical Leave Act (FMLA) & Uniformed Services Employment & Re-employment Rights Act (USERRA)

These options are available only if your Planholder is legally required to allow for a family leave of absence. You can confirm with your Planholder if these options are available.

If these options are available to you, you can keep this coverage when you take a leave of absence approved by your Planholder for one of the following reasons:

- To care for a seriously injured or ill spouse, child, or parent
- Within 12 months following the birth or adoption of a child
- Due to your own serious health condition
- To care for a spouse, child, parent or next of kin, who's your closest blood relative, that suffered a sickness or injury while on active duty in the US Armed Forces

You can keep this coverage while on leave for up to 12 weeks in any 12-month period. However, if the leave is to care for a family member who was injured or became ill while on active duty, as explained above, you'll be able to keep this coverage for up to 26 weeks of leave in a 12-month period.

If you take a family leave for any other reason during this same 12-month period, this will count toward the 26-week maximum.

Any subsequent leave to care for a service member will be limited to 12 weeks.

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All Options

Family coverage

Who's eligible

The following family members are eligible for coverage:

- Your spouse, civil union partner or domestic partner

A spouse is the person to whom you're legally married, your civil union partner, or your domestic partner.

Your domestic partner is the person of the same or different sex with whom you live and share financial assets and obligations. Your domestic partner must be able to provide legal consent and can't be a blood relative. You and your domestic partner may not be married to, in a domestic partnership with, or legally separated from anyone else.

Your domestic partnership must be registered with a state or local government registry.

We won't require proof of registered domestic partnership that we wouldn't require of a marriage.

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All Options

- Your child, who's
 - Under the age of 26

Your child is one of the following:

- Your biological child
- Your stepchild
- A child placed with you for adoption or foster care
- A child for whom you've been appointed a legal guardian and who you claim as a dependent on your federal income taxes

A child who's incapable of self-support because of mental, physical, or developmental disability may be able to keep this coverage past the maximum age. See the **Keeping this coverage for a child who reaches the age limit** section.

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All Options

Family members that aren't eligible

- A family member who's on active duty in the armed forces.
- A child who's an eligible dependent of more than one member can be covered through only one member.
- A family member who's also eligible for coverage as a member under this Plan can't be covered more than once.

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All Options

How to get coverage for your family

If your family member(s) are eligible, you must do the following to obtain coverage:

You must be enrolled

In order to enroll your family members, you must already be enrolled for coverage, or you must enroll yourself when you enroll them.

You must enroll your family members

You can enroll your eligible family members when they first become eligible.

You can enroll family members when there's a qualifying life event

You can also enroll an eligible family member within 31 days of a qualifying event. This includes:

- Your marriage or entrance into a domestic partnership
- Your legal separation or divorce or dissolution of a civil union or domestic partnership
- The death of your spouse
- The birth or adoption of your child or your assuming legal responsibility for a foster child
- Your spouse's loss of coverage under another dental plan
- Your spouse's loss of employment

Your biological children are automatically covered for the first 31 days following their birth. Your adopted children and foster children are automatically covered for the first 31 days from the date they are placed in your care.

You must enroll biological, adopted, and foster children and pay the required premium within this 31-day period or their coverage will end when the 31 days are over.

What happens if you enroll family members late

If you didn't enroll your eligible family members within the time allowed, you'll be able to enroll them during the next open enrollment period.

They may have to satisfy a waiting period because you enrolled them late. See the **Waiting period if you enroll late** section for more information.

The premium must be paid

We must receive the required premium for family coverage.

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All Options

When family coverage begins

If you enrolled your family members when you enrolled yourself, their coverage begins at the same time your coverage begins. If you did not enroll your family members at the same time you enrolled yourself, their coverage will begin at 12:01 AM EST on the date you enroll them.

B650.0499

All Options

When family coverage ends

Coverage for your family member will end at 11:59 PM EST on the earliest of the following:

- The date your coverage ends.
- The date you stop being a member of a class that's eligible for family member coverage.
- The last day of the period for which the required premiums were paid.

- For a spouse, the last day of the month in which your marriage ends in divorce or annulment or your civil union or domestic partnership is dissolved.
- For a child, the last day of the month in which your child reaches the maximum age or no longer meets the conditions listed under **Keeping this coverage for a child who reaches the age limit**.
- The date the family member becomes ineligible for any of the reasons listed in the **Family members that aren't eligible** section.
- The date the family member dies.

If your coverage ends because of your death, your family members may continue their coverage in accordance with the **Family survivorship benefit**. See the **Family survivorship benefit** for more information.

B650.0505

All Options

Keeping this coverage for a child who reaches the age limit

A child may keep this coverage past the age limit if the child is all the following:

- Unable to live independently due to a mental, physical, or developmental disability, injury, illness, or condition which began before reaching the maximum age
- Primarily dependent upon you for financial support
- Continuously covered by this Plan, or by the group plan this Plan replaced, through the time the maximum age was reached

You'll have to send us proof that your child meets these requirements within 60 days of the date the maximum age was reached.

After two years have passed from the date the maximum age was reached, we may periodically ask for documentation that your child continues to meet these requirements. We won't ask for this more than once a year.

Coverage extended in accordance with this section will end when your child no longer meets the conditions above. Even when your child does meet the requirements listed above, this coverage can end due to any of the reasons, other than reaching the maximum age, listed under the **When family coverage ends** section.

B650.1135

All Options

Family survivorship benefit

If you die while you're covered by this Plan, we'll continue to provide coverage to any family members that were covered by this guide at the time of your death. This continued coverage will be provided at no cost to them.

We'll continue to cover your family members for 6 months after the date of your death. Coverage will end on the date this 6-month period ends.

The coverage will end sooner:

- For any family member whose coverage ends for other reasons - see the **Family coverage** section for more information
- For your spouse, upon remarriage
- If this Plan ends

Coverage will end on the date any of above occur.

If a family member elects to keep coverage under COBRA, the family survivorship benefit will be provided during the first 6 months of the continuation. See **COBRA continuation rights** for more information.

B650.0501

All Options

Other things you should know

Paying the premiums

For your insurance coverage to be in place, the required premiums must be paid. We worked with your Planholder to decide how and when the premium payments must be made.

The premiums can be changed at any time. We'll give your Planholder 31 days advance notice of any change in premiums.

If you have any questions about premium payments, please contact the Planholder.

Be sure to give us complete and accurate information

If we asked you to provide personal, health or medical information about yourself or your family members at the time of enrollment, it's important that the information you provided was complete and accurate. If it wasn't, we have the right to challenge a claim for benefits. This means we can deny a claim that might otherwise be covered.

If you don't give us complete and accurate information, we may also have the right to rescind this coverage. This means we would declare your guide to be null and void as of its effective date. In that case, we'd refund all the premiums paid and it would be as though your insurance coverage had never been issued.

During the first two years this guide is effective, we can rescind it if any material information you provided in or with an enrollment form or application was missing or inaccurate.

Information is considered material if it would have caused us to:

- Not issue any coverage
- Issue your guide with different coverage or benefit amounts
- Issue your guide with different premium amounts

After this guide has been in place for more than two years, we can only rescind it if you committed fraud.

We won't challenge a claim or contest whether this coverage is valid unless the statement in question was made in writing and signed by you.

All statements made in your application will be considered representations, not warranties. This means you're asserting that the information you have listed on your application is accurate. You're not, however, promising to do anything for us if this assertion turns out to be false.

Any increase in benefits will be subject to these same requirements, with the two years described above beginning on the effective date of the increase.

Review the information you provided at the time of enrollment or application to make sure it's complete and accurate. If you find anything is missing or inaccurate, you must immediately notify us in writing at the address listed on the first page of this guide.

Misstatement of age

If your age or a family member's age is found to be incorrect, we may need to make an adjustment in the coverage and the premiums.

If the true age would have prevented us from issuing any coverage, this coverage will be terminated from the beginning and a refund of premiums will be made. Any benefits previously paid will be deducted from the refund.

Advance notice of change

We'll provide written notification at least 60 days prior to any of the following:

- Plan termination
- Premium increases
- Benefit reduction or elimination
- Eligibility restrictions

B650.1136



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

Covered services guide

This is the covered services guide

This guide explains the dental services that are covered and how much we'll pay.

We're here to help. Contact us if you have any questions or want to talk about any part of this guide.

1-800-541-7846

guardianlife.com

Planholder: SAINT FRANCIS HIGH SCHOOL

Plan Number: 00051756

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a network dentist may charge you their usual and customary rate for those services. Prior to providing you with dental services that are not a covered benefit, the dentist should provide to you a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call us at 1-888-GUARDIAN. To fully understand your coverage, you may wish to carefully review this document.

B651.1241

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Guide basics

Covered dental services

For a dental service to be considered for benefits:

- The service must be provided while you're covered by this Plan. If the service is for a family member, it must be provided while the family member is covered by this Plan. Unless we say otherwise in this guide, the date the dental service is performed will be the date we use to determine the benefits available.
- The service must be provided by a dental or medical practitioner who's properly licensed or certified by the state where the services are provided, and who provides dental services within the scope of this license or certification.
- The service must be provided within the professionally accepted standards of dental practices and be necessary and appropriate for your dental condition.
- The service must be covered by this guide.

There are many different dental services you can receive. This Covered Services Guide lists the most common services, but there can be other dental services not listed here that may also be covered. You or your dentist can contact us with any questions about any dental service you don't see in this guide.

Your dentist will give us a CDT (Current Dental Terminology) code to tell us which service you received. These CDT codes are approved by the American Dental Association and are used by all dentists.

Because dental terminology is updated from time to time, the most current dental terminology may not be reflected in this guide. We'll use the most current dental terminology when we receive your claim and determine the benefits payable.

Some dental services involve more than one procedure. Each procedure will be considered part of the overall service when we determine the benefits payable.

You and your dentist have the right and responsibility to decide upon the best course of treatment for you based on your dental needs, regardless of what benefits may be available. If more than one dental service can be used to treat your dental condition, we'll use the least costly option when we determine the benefits payable.

What we pay

In the Member Guide, we told you about deductibles and benefit maximums. In this guide, we'll give you the details on how much of the dentist's fees we'll pay.

How often

This is where we tell you how often you can have the service and receive the benefits available for that service.

Other things you should know

Here, we'll give you a brief description of each service and tell you other things you need to know about the benefits available.

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Office Visits, X-rays & Cleanings - Diagnostic & Preventive Care

Office visits & evaluations

This section explains the benefits available when you go to the dentist for an office visit or evaluation.

Office visits, oral evaluations & comprehensive evaluations Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 2 time(s) every 12 months
- 1 time every 36 months for comprehensive evaluations per dentist

Other things you should know:

- These include any regular check-ups and dental evaluations.
- Office visits and evaluations count toward the same maximum number allowed.

Emergency problem-focused evaluations Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 1 time every 6 months

Other things you should know:

- This type of evaluation may be needed when there is a specific dental problem that needs attention right away.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

After-hours office visits & palliative treatment visits Preventive

What we pay:

- When you use an in-network dentist 100%
- When you use an out of network dentist 100%

How often:

- 1 time every 6 months

Other things you should know:

- After-hours visits take place outside normal office hours.
- Palliative treatment is provided to relieve pain or discomfort.
- After-hours visits and palliative treatment visits count toward the same maximum number allowed.
- This benefit is available when no other services besides X-rays are performed during the visit. If other services are performed, refer to those services for the benefits available.

X-rays - radiographic images

This section explains the benefits available for the various types of X-rays or images your dentist may take during your dental visit. Your dentist may refer to X-rays as radiographic images.

Complete series & panoramic X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) every 36 months

Other things you should know:

- A complete series captures an image of every tooth.
- A panoramic X-ray shows all the teeth, surrounding bone and other structures in the mouth.
- Complete series X-rays and panoramic X-rays count toward the same maximum number allowed.

Bitewing X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) every 12 months

Other things you should know:

- These X-rays show gum disease and cavities between the teeth.
- This benefit is available for a total of 4 bitewing images, or vertical bitewing images in 1 visit.

Intraoral periapical & occlusal X-rays Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- As needed

Other things you should know:

- A periapical X-ray is a single X-ray that shows the whole tooth, including the roots.
- An occlusal X-ray is a single X-ray that shows the roof or floor of the mouth.

Dental cleanings, preventive care & other diagnostic services

This section explains the benefits available for cleanings and other types of preventive care aimed at keeping your teeth and gums healthy.

Dental cleanings Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 2 time(s) every 12 months
- 1 time every 12 months for a medically necessary cleaning

Other things you should know:

- This removes plaque, tartar, and stains from the teeth. It can be performed by a dentist or dental hygienist. Your dentist may call this a prophylaxis.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- This benefit for an additional cleaning is available if the cleaning is needed because of health conditions.
We may ask that your physician provide a written explanation of why an additional cleaning is needed.

Fluoride Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 2 time(s) every 12 months

Other things you should know:

- This helps prevent cavities by strengthening the outer surface of the teeth. Fluoride can be applied to the teeth as a mouth rinse, gel, or foam.
- This benefit is only available for those under the age of 14.

Sealants Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 time(s) per tooth every 36 months

Other things you should know:

- These are thin, protective resin coatings that adhere to the chewing surface of the back teeth to help prevent cavities.
- This benefit is only available for those under the age of 16.
- This benefit is only available for adult (permanent) molar teeth that don't already have fillings or other treatments on the tooth.

Space maintainer Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 appliance during the lifetime of this plan

Other things you should know:

- This appliance helps preserve space for adult (permanent) teeth when 1 or more baby (primary) teeth are lost too early.
- This benefit is available only for those under the age of 16.
- This benefit is available for 1 bilateral space maintainer for the upper teeth and 1 for the lower teeth, or 1 unilateral space maintainer per quadrant.
The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the space maintainer, including adjustments made within 6 months and re-cementations made within 12 months of the space maintainer being inserted, will be considered part of the space maintainer.

Harmful habit appliance Preventive

What we pay:

- When you use an in-network dentist **100%**
- When you use an out of network dentist **100%**

How often:

- 1 appliance during the lifetime of this plan

Other things you should know:

- This appliance is temporarily cemented to certain teeth to prevent a child from sucking a thumb, finger, or pacifier.
- This benefit is available only for those under the age of 14.

Dental model Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 model

Other things you should know:

- These are replicas of the upper or lower teeth and are made of stone or plaster. Your dentist may call this a diagnostic cast.
- This benefit is only available when 3 or more of the following are needed at the same time for both the upper and lower teeth:
 - Dentures
 - Crowns
 - Bridges
 - Onlays
 - Full mouth adjustment of the bite

Fillings, Crowns & Other Repairs - Tooth Restorations

Fillings

This section explains the benefits available for dental fillings.

Fillings **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth surface every 12 months for those under the age of 19 and 1 time per tooth surface every 36 months for those age 19 and older.

Other things you should know:

- These are used to restore a tooth damaged by decay or when part of a tooth has broken off. Your dentist may call a silver-colored filling an amalgam restoration. Your dentist may call a tooth-colored filling a resin or composite restoration.
- All services associated with a filling, such as bonding agents, liners, bases, polishing, bite adjustments, and local anesthetic, will be considered part of the filling.

Crowns

This section explains the benefits available when you have a crown placed on a tooth.

Crowns Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a crown. This is sometimes called a cap.
- A crown can be made of metal, porcelain (a tooth-colored material), or both, where porcelain covers the metal underneath.
- This benefit is available only when the crown is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- A crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and it can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a crown, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the crown.
- The day the tooth is prepared for the crown will be considered the date the service is performed.

Prefabricated crowns Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth every 24 months

Other things you should know:

- When a tooth has been damaged by decay or part of a tooth has broken and it can't be repaired with a filling, the tooth may be restored to normal function with a prefabricated crown. Prefabricated crowns are usually used on baby (primary) teeth.
- A crown can be made of stainless steel, porcelain (a tooth-colored material), resin (also a tooth-colored material) or a combination, where porcelain covers the metal underneath.
- When a prefabricated crown is replaced within 24 months by a permanent crown, the prefabricated crown will be considered temporary and part of the permanent restoration.

Other tooth restoration services

This section explains the benefits available for other types of restorations or repairs your teeth may need.

Onlays & labial veneers Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used when a filling can't be used to restore a tooth damaged by decay or replace a part of the tooth that has broken off.
- Onlays are like crowns, but instead of covering the entire tooth, they cover only the damaged part of the tooth.
- A veneer is a tooth-colored material that's placed on the front of the tooth. These are used on anterior teeth only. These are the incisor and cuspid teeth located in the front of the mouth.
- This benefit is available only when the restoration is needed because of decay or missing tooth structure and the tooth can't be restored with a filling.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain onlay is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For an onlay placed on a molar tooth, what we pay will be based on the cost of an all-metal onlay
- The benefit for a noble metal onlay is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal onlay.
- An onlay or veneer that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with the restoration, such as insulating bases, temporary or provisional restorations, local anesthetic or associated gingival involvement, will be considered part of the restoration.
- The day the tooth is prepared for the restoration will be considered the date the service is performed.

Core buildup & post & core Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the restoration must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- A core buildup and a post and core are done to strengthen a tooth that has been broken or damaged by decay so a crown can be placed.
- This benefit is available only when this service is done with a covered crown or bridge retainer and when needed because of substantial loss of tooth structure.
- This benefit is available for adult (permanent) teeth only.

Crown & restoration repairs Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- Sometimes a crown, onlay or veneer can be repaired instead of replaced.

Re-cement & re-bond Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- Sometimes a crown, onlay or veneer may need to be re-cemented or re-bonded.
- This benefit is available if the re-cement or re-bond is done more than 12 months after the placement of the restoration.

Root Canals & Related Services - Endodontic Care

Root canals

This section explains the benefits available when you have a root canal performed.

Root canal - anterior & bicuspid teeth **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Root canal - molar teeth **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth
- If a tooth needs to be retreated, this benefit is available 1 time per tooth.

Other things you should know:

- This is done to remove the nerve inside the tooth. A filling is placed where the nerve used to be. Your dentist may call this endodontic therapy.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a root canal, such as X-ray images, cultures and tests, local anesthetic, the protective restoration, and routine follow up care, will be considered part of the root canal.
- The day the tooth is initially opened for a root canal will be considered the date the service is performed.

Other endodontic services

This section explains the benefits available for other endodontic procedures.

Pulp cap Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth

Other things you should know:

- This is a special material placed underneath a filling to protect the nerve inside the tooth.
- This benefit is available for adult (permanent) teeth only.
- All services associated with a pulp cap, such as X-rays, cultures and tests, local anesthetic, temporary filling, and routine follow up care, will be considered part of the pulp cap.

Pulpotomy Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- This involves removing the nerve inside the tooth.
- When a root canal is the final treatment, this service will be considered part of the root canal.
- All services for treatment associated with a pulpotomy, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the pulpotomy.

Apicoectomy, retrograde filling & root amputation Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time per tooth root for each procedure

Other things you should know:

- An apicoectomy is the surgical removal of the tip of the tooth root.
- A retrograde filling is used to seal the site of the root tip removal.
- A root amputation is the surgical removal of a root from a tooth that has multiple roots.
- All services associated with these procedures, such as diagnosis, X-rays, cultures and tests, local anesthetic, protective restoration, and routine follow up care, will be considered part of the procedure.

Periodontal Care - Treatment of Gum Disease & Related Services

Non-surgical periodontal services

This section explains the benefits available when you receive periodontic care that doesn't involve surgery.

Periodontal maintenance Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 2 time(s) every 12 months

Other things you should know:

- This is a specialized cleaning that may be needed after any type of previous periodontal treatment. Your dentist may call this a periodontal prophylaxis or periodontal cleaning.
- Periodontal maintenance visits will count toward the number of dental cleanings allowed. Dental cleanings will also count toward the number of periodontal maintenance visits allowed.
- All services associated with periodontal maintenance, including the treatment plan, charting, scaling, polishing, local anesthetic, and post- treatment care, will be considered part of the periodontal maintenance.

Scaling & root planing Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time(s) per quadrant every 24 months

Other things you should know:

- This is a cleaning of tooth surfaces both above and below the gumline. It may be necessary when there's periodontal disease and chronic inflammation in the gum tissue around the teeth that causes a breakdown in some of the nearby bone.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- The upper teeth and the lower teeth are each divided into 2 quadrants, a right side, and a left side.
- All services associated with the scaling and root planing, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the scaling and root planing.

Full mouth debridement Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time during the lifetime of this plan

Other things you should know:

- This is an extensive cleaning needed when the teeth can't be examined because of a significant amount of plaque and buildup on them.
- All services associated with the debridement, including the treatment plan, charting, scaling, polishing, local anesthetic, and post-treatment care, will be considered part of the debridement.

Periodontal surgery

This section explains the benefits available when you have periodontic surgery.

Gingivectomy, gingivoplasty (1 to 3 teeth) & crown lengthening Basic

What we pay:

- When you use an in-network dentist 80%
- When you use an out of network dentist 80%

How often:

- 1 surgical procedure per tooth every 12 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Crown lengthening removes a small amount of bone and gum tissue around a tooth to make a crown fit better.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray. This benefit will be available for a gingivectomy of 1 tooth when there is documented inflammation of the gum tissue.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Gingivectomy, gingivoplasty (4 or more teeth), osseous surgery, gingival flap procedure, mesial/distal wedge procedure & surgical revision procedure Basic

What we pay:

- When you use an in-network dentist 80%
- When you use an out of network dentist 80%

How often:

- 1 surgical procedure per quadrant every 36 months

Other things you should know:

- A gingivectomy and gingivoplasty removes excess or inflamed gum tissue.
- Osseous surgery reshapes the bone around the tooth.
- Gingival flap, mesial/distal wedge and surgical revision procedures reshape the gum tissue around a tooth, teeth, or spaces without teeth.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- All services associated with these surgical procedures, including the treatment plan, charting, irrigation, local anesthetic, suturing and post-surgical care, will be considered part of the surgical procedure.

Tissue graft Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time(s) per tooth or site every 36 months

Other things you should know:

- This involves replacing gum tissue that has been lost around the root area of a tooth.
- This benefit is available only when there's documentation of progressive loss of gum tissue due to disease.
- This benefit is available only when the tooth is present.
- This benefit is available only when this procedure is necessary as part of a covered implant placement.
- All services associated with the graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the graft.

Guided tissue regeneration Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time(s) per tooth or site

Other things you should know:

- This is used to replace gum tissue. It's frequently done with a bone graft to replace bone that has been lost.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the regeneration, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care will be considered part of the regeneration.

Bone replacement graft Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 time(s) per tooth or site

Other things you should know:

- This involves replacing bone tissue that has been destroyed by periodontal disease.
- This benefit will be available only when there's periodontal disease documented by charting of pockets in the gums and bone loss that's verified by X-ray.
- This benefit is available only when the tooth is present.
- All services associated with the bone graft, including the treatment plan, charting, irrigation, suturing, local anesthetic, and post-surgical care, will be considered part of the bone graft.

Periodontal related services

This section explains the benefits available for other periodontal related services.

Limited occlusal adjustment Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 2 visits

Other things you should know:

- This is a minor adjustment of the biting surfaces of 1 or more teeth.
- This benefit will be available only for adjustments made within 6 months after osseous surgery and scaling and root planing.

Occlusal guard Basic

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- 1 appliance during the lifetime of this Plan

Other things you should know:

- This appliance covers some or all the teeth. There are different types of guards used for different types of treatment.
- This benefit is available only when the guard is received within 6 months after osseous surgery.

Bridges & Dentures - Prosthodontics

Bridges

This section explains the benefits available when you have a bridge made and placed.

Bridges **Major**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the bridge must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- This a fixed prosthetic that replaces 1 or more missing teeth and is held in place by adjacent teeth. Your dentist may refer to the false teeth as pontics and to the adjacent teeth as abutments.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain bridge is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a bridge placed on molar teeth, what we pay will be based on the cost of an all-metal bridge.
- The benefit for a noble metal bridge is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal bridge.
- A bridge that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.
- All services associated with a bridge, including insulating bases, temporary or provisional restorations, local anesthetic, or gingival involvement, will be considered part of the bridge.
- The day the tooth is initially prepared for the bridge will be considered the date the service is performed.

Dentures

This section explains the benefits available when you have a denture made and placed.

Dentures - partial & complete Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time every 5 years for each denture
- For a replacement, the denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are removable dental prostheses used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete denture replaces all the upper teeth or all the lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- The day the final impression is taken for the denture will be considered the date the service is performed.
- If a temporary, interim, or provisional denture is in place for more than 1 year, it will be considered a permanent denture.
- All services associated with a denture, including a temporary denture and adjustments made in the first 6 months after the denture is placed, will be considered part of the denture.
- A denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bridge & denture repairs & maintenance

This section explains the benefits available when a bridge or denture needs to be repaired or modified.

Bridge repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- A bridge may need to be repaired due to wear or other damage.

Denture repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- A denture may need to be repaired due to wear or other damage.

Denture adjustments Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- Adjustments involve making changes to the denture to ensure a proper fit.
- Any charges for denture adjustment done within 6 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the adjustment is done more than 6 months after the denture was placed or more than 6 months after the most recent denture rebase or denture reline.

Adding teeth to partial dentures Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- A partial denture may need to be modified if additional teeth are lost after it was first placed.

Denture rebase Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per denture every 24 months

Other things you should know:

- This involves replacing the entire acrylic denture base without replacing the artificial teeth.
- Any charges for a denture rebase done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.
- This benefit is available only when the rebase is done more than 12 months after the denture was placed.

Denture reline Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per denture every 24 months

Other things you should know:

- This involves reshaping the denture base to make it more comfortable.
- Any charges for a denture reline done within 12 months after the denture was placed will be considered part of the fee for the denture if its done by the same dentist that provided the denture.
- This benefit is available only when the reline is done more than 12 months after the denture was placed.

Tissue conditioning Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time for the upper denture and 1 time for the lower denture every 12 months

Other things you should know:

- This is a temporary cushion placed inside a denture to improve fit and comfort following an extraction or other surgical procedure.
- Any charges for tissue conditioning done within 12 months after the denture was placed will be considered part of the fee for the denture if it's done by the same dentist that provided the denture.

Dental Implants

Implants

This section explains the benefits available when you have a dental implant placed.

Radiographic/surgical implant index Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time for the upper teeth and 1 time for the lower teeth every 24 months

Other things you should know:

- This is a customized template used to guide the correct placement of the implant.

Surgical placement of implant Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- An implant is like a post and is surgically placed into the jawbone.
- This benefit is available for adult (permanent) teeth only.
- All services associated with an implant, such as the treatment plan, local anesthetic, and post-surgical care, will be considered part of the implant.
- An implant that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Other implant related services

This section explains the benefits available for other services related to dental implants.

Implant abutments - prefabricated & custom fabricated Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant abutment must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These attach to the implant and connect the implant to the implant crown, bridge, or denture.
- An implant abutment that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported crowns Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth every 5 years
- For a replacement, the implant crown must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are screwed or cemented onto the abutment to replace the missing tooth.
- This benefit is available for adult (permanent) teeth only.
- The benefit for a porcelain crown is available for anterior and bicuspid teeth only. These are all the teeth except for the molars. For a crown placed on a molar tooth, what we pay will be based on the cost of an all-metal crown.
- The benefit for a noble metal crown is available for all teeth. If a more expensive material is used, what we pay will be based on the cost of a noble metal crown.
- An implant crown that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Implant/abutment-supported dentures Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per denture every 5 years
- For a replacement, the implant denture must be at least 5 years old, damaged, no longer useable, and not repairable.

Other things you should know:

- These are used to replace missing teeth. A partial denture replaces 1 or more upper teeth or 1 or more lower teeth. A complete implant denture replaces all the upper teeth or lower teeth.
- This benefit is available to replace adult (permanent) teeth only.
- An implant denture that's damaged from an injury that occurs while you're covered by this Plan can be replaced if it's no longer useable and can't be repaired. Damage that results from chewing or biting food or another substance won't be considered damage from an injury.

Bone replacement graft for ridge preservation Major

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- 1 time per tooth or area

Other things you should know:

- This involves replacing bone tissue that has been lost because of an extraction or implant removal.
- This benefit is available only when the procedure is done with a covered dental implant in the same site.

Implant repairs & removal

This section explains the benefits available when you have an implant abutment, crown or denture that needs to be repaired or an implant that needs to be removed.

Implant crown & implant denture repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- An implant supported crown or denture may need to be repaired due to wear or other damage.

Implant abutment repairs Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- As needed

Other things you should know:

- An implant abutment may need to be repaired due to wear or other damage.

Implant removal Major

What we pay:

- When you use an in-network dentist 50%
- When you use an out of network dentist 50%

How often:

- 1 time per tooth

Other things you should know:

- This involves removing an implant from the jaw.

Tooth Extractions & Oral Surgery

Extractions

This section explains the benefits available when you have a tooth removed.

Non-surgical extractions **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- This is done to remove a tooth or root that's above the gumline.
- All services associated with the extraction, such as the treatment plan, local anesthetic, and post-treatment care, will be considered part of the extraction.

Complex surgical extractions **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- This is done when the extraction involves cutting the gums or bone to remove the tooth or roots.
- All services associated with the extraction, such as the treatment plan, local anesthetic, suturing and post-surgical care, will be considered part of the extraction.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information.

Other oral surgery services

This section explains the benefits available for other oral surgery procedures.

Other complex oral surgeries **Basic**

What we pay:

- When you use an in-network dentist **80%**
- When you use an out of network dentist **80%**

How often:

- As needed

Other things you should know:

- Other types of oral surgery may be needed to treat oral diseases, injuries, and defects.
- All services associated with the surgery, such as X-rays, the treatment plan, local anesthetic, suturing, and post-surgical care, will be considered part of the surgery.
- These procedures may be covered by your medical plan. See the **Other things you should know about claims** section of the Member Guide for more information

Other Dental Services

This section explains the benefits available when you receive one of the following services.

Anesthesia Basic

What we pay:

- When you use an in-network dentist 80%
- When you use an out of network dentist 80%

How often:

- As needed

Other things you should know:

- This is a drug administered during procedures to reduce pain or discomfort. This includes:
 - Deep sedation/general anesthesia
 - Intravenous conscious sedation
 - Non-intravenous conscious sedation
 - Nitrous oxide
- This benefit is available only when the anesthesia is administered with a covered surgical service.

Consultations Basic

What we pay:

- When you use an in-network dentist 80%
- When you use an out of network dentist 80%

How often:

- 1 time for each dental specialty every 12 months

Other things you should know:

- This is an examination performed by a specialty dentist or a dentist other than your usual dentist.
- This benefit is available only when the dentist providing the consultation isn't the same dentist providing your treatment.
- This benefit is available only when no other services, other than X-rays, are performed during the consultation. If other services are performed, refer to those services for the benefits available.

Orthodontic Care

This section explains the benefits available when you have your teeth straightened or realigned.

Orthodontic services **Orthodontic**

What we pay:

- When you use an in-network dentist **50%**
- When you use an out of network dentist **50%**

How often:

- As needed

Other things you should know:

- These services correct the position of the teeth and jaw.
- This benefit is available for adults and children.
- This benefit is available for the orthodontic treatment plan and records, including impressions, X-rays, photographs, study models, braces or clear aligners, periodic visits, and retainers.
- This benefit will be divided into equal payments and will be made over the length of the treatment plan or 2 years, whichever is shorter. The first payment will be made when the appliances are initially placed. The remaining payments will be made at the end of every quarter.
- If the orthodontic treatment began before your coverage under this Plan started, the treatment will be pro-rated. For example, if 40% of the treatment was completed before coverage under this Plan began, only the remaining 60% will be considered.
- The day the appliances are first placed will be considered the date the service begins.
- Any benefits that were paid for orthodontic services under a prior plan will reduce the orthodontic lifetime maximum by an equal amount. See the Benefit maximums section of the Member Guide for more information.
- Discounts offered by dentists in our network aren't available for:
 - Additional charges for optional orthodontic appliances
 - Replacement or repair of an orthodontic appliance needed due to neglect
 - Orthodontic treatment plans that began before you became eligible for benefits for orthodontic services under this plan.
- There's a maximum amount of benefits that will be paid for orthodontic care. See the **Benefit maximums** section for this amount.

What isn't covered - exclusions

This section explains the services that aren't covered by this Plan.

No benefits are available for:

- Any service for which there is no charge
- Any service that doesn't meet professionally recognized standards of dental practice or that's considered to be experimental
- Any service that's performed in conjunction with or related to a service that isn't covered by this guide
- Any service on a tooth with a guarded, questionable, or poor prognosis
- Any service that's used solely to:
 - Alter occlusal vertical dimensions
 - Restore or maintain occlusion
 - Treat a condition resulting from attrition, abrasion, erosion or abfraction
 - Splint or stabilize teeth for periodontal reasons
- Replacing extracted or missing wisdom teeth
- Localized use of antimicrobial agents into diseased crevicular tissue
- Any service that's provided solely for cosmetic reasons, such as teeth whitening, characterization, or personalization of a dental prosthesis, or odontoplasty.
- Replacement of a lost, missing, or stolen appliance or dental prosthesis, or the fabrication of a spare appliance or dental prosthesis
- Upgrading from one appliance or dental prosthesis to another appliance or dental prosthesis, such as replacing a bridge with a dental implant or replacing a denture with a bridge
- A temporary or provisional appliance or dental prosthesis, unless it's an interim partial denture that replaces anterior teeth extracted while this coverage was in place. These are the incisor and cuspid teeth located in the front of the mouth.
- A bridge that replaces the extracted portion of a hemisected tooth
- The placement of more than one crown or bridge unit per tooth
- Overdentures and related services, including root canal therapy on teeth supporting the overdenture
- Detailed and extensive oral evaluations
- Any service that's educational or instructional, such as oral hygiene instruction, tobacco counseling or nutritional counseling
- Bite registration, bite analysis or occlusion analysis - mounted case
- Duplication of X-rays
- Completion of claim forms
- OSHA or other infection control measures
- Cephalometric X-rays
- Cone beam images
- Oral or facial photographs
- Prescription medication
- Application of desensitizing medications and resins
- Separate charges for local anesthesia
- Pulp vitality tests
- Caries susceptibility tests
- Specialized techniques
- Precision attachments
- Maxillofacial prosthetics to repair facial or skeletal anomalies, maxillofacial surgery, orthognathic surgery, or any oral surgery requiring the setting of a fracture or dislocation that results from or is incidental to a medical condition
- Treatment of congenital or developmental malformations or the replacement of congenitally missing teeth
- Any service intended to treat or diagnose disorders of the temporomandibular joint (TMJ)

- Any service coded by the dentist as unspecified
- The isolation of a tooth with a rubber dam
- Gingival irrigation
- Medications dispensed in a dental office for home use

B651.1249

All Options

Here is a notice to help you better understand your rights if your Plan is governed by ERISA. The notice isn't part of the group insurance policy or member guide.

B651.1025

All Options

Statement of ERISA Rights

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law 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 Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

You and your beneficiaries can obtain, without charge, from the plan administrator, a copy of any procedures governing Qualified Domestic Relations Orders (QDRO) and QMCSO. You may also obtain this information on the U.S. Department of Labor's website or you may contact them in your telephone directory.

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

If you have questions about this section, see your plan administrator.

Dental Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from the plan administrator.

The plan administrator 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. The plan administrator has discretionary authority to determine eligibility for benefits and coverage under those documents. The plan administrator 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, the plan administrator will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of ERISA.

Definitions

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

Timing for Initial Benefit Determination

The Benefit Determination period begins when a claim is received. The plan administrator, or its designee, 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.

The plan administrator, or its designee, 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 the plan administrator, or its designee, 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 the plan administrator, or its designee, 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 the plan administrator, or its designee, 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, the plan administrator, or its designee, 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. The plan administrator, or its designee, 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, the plan administrator, or its designee, will:

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

- In deciding an appeal based upon a dental or medical judgement, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify dental or medical experts whose advice was obtained in connection with an Adverse Benefit Determination;
- 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.

The plan administrator, or its designee, 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 the plan administrator, or its designee, 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 the plan administrator, or its designee, 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.

B651.1054

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

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

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

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

The Group Vision Insurance Coverage described in this Certificate is attached to the group Policy effective July 1, 2023. 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: SAINT FRANCIS HIGH SCHOOL

Group Policy Number: 00051756

Effective Date: July 1, 2023



Michael Prestileo,
Senior Vice President



Harris Oliner, Senior Vice President
and Corporate Secretary

B435.0959

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All Options

NOTICE: WE WILL PROVIDE WRITTEN NOTIFICATION BY MAIL TO THE LAST KNOWN ADDRESS OF ALL AFFECTED NONEMPLOYEE CERTIFICATE HOLDERS AT LEAST 60 DAYS PRIOR TO THE EFFECTIVE DATE OF THE FOLLOWING: TERMINATION OF THE PLAN, INCREASE IN PREMIUM, REDUCTION OR ELIMINATION OF BENEFITS OR RESTRICTION OF ELIGIBILITY NOT REQUESTED BY THE PLANHOLDER.

SHOULD YOU HAVE ANY QUESTIONS REGARDING THIS INSURANCE, YOU MAY CONTACT THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA AS SHOWN BELOW.

COMPLAINT NOTICE

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

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

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

**Department Of Insurance
300 South Spring Street
Los Angeles, California 90013
Consumer Hotline: 1 (800) 927-HELP (4357)
TDD: 1 (800) 482-4TDD (4833)
Website: www.insurance.ca.gov/01-consumers/**

B435.1293

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, subject to a grace period of 31 days.

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 during the 2 years from its date of issue, We will refund premiums paid for the periods such insurance is void.

B435.1294

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 or Qualified Retiree; 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 May 1st to June 30th 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.

B435.0971

All Options

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
 - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
 - A child who is incapable of self-support because of a physical or mentally disabling injury, illness or condition. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:
 - The condition started before he or she reached the age limit; and
 - The child remained continuously covered until he or she reached the age limit; and
 - We will send notice to You to send Us written proof that the child is dependent upon You for support and maintenance and is incapable of self-sustaining employment by reason of a disabling physical or mental injury, illness, or condition. You have 60 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 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.

B435.1295

All Options

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

All Options

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

All Options

Exception to When Coverage Starts

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

- A holiday;
- A vacation day;
- A non-scheduled work day;

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

All Options

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

All Options

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

All Options

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

All Options

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

All Options

VISION CLAIM PROVISIONS

You may visit any provider. After VSP 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 VSP's fee schedule for Your specific Policy. Please refer to Your Schedule of Benefits.

B435.0520

All Options

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 his or her name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

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 occurrence, the character and the extent of the loss for which claim is 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 after We receive written proof of loss, subject to all the terms and conditions of this Policy.

Unless otherwise required by law or regulation, We pay all Vision benefits to You if You are living. If You are not living, Vision benefits shall be paid to Your estate, except that We may pay all Vision benefits, up to an amount not exceeding \$1000, to one of the following:

Your:

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

Any payment We make in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

All claims must be sent to VSP 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 Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

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.

B435.1301

Adverse Benefit Determination

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

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

B400.3339

Appeal of Adverse Benefit Determinations

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

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

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

External Reviews And Independent Medical Reviews

In the event that You believe a claim was improperly denied, modified or delayed by Guardian or one of Our providers due to the proposed health care services being not medically necessary, You have the right to request an Independent Medical Review (IMR) by the California Department of Insurance (CDI). You must request an external review within 60 days receipt of the adverse benefit determination notice.

With regard to experimental or investigative therapies, We will notify You of the right to request an IMR within 5 business days of the adverse benefit determination notice. If Your physician determines that the proposed therapy would be significantly less effective if not promptly initiated, You can request an expedited review and the analyses and recommendations of the panel of experts will be rendered within seven days of the request for expedited review. At the request of the expert(s), the deadline can be extended by up to three days. The IMR for experimental and investigative therapies will follow the standard procedures except that the reviewer will base his or her determination on relevant medical and scientific evidence.

You can request an IMR by following the steps outlined below.

1. Notify the CDI to request an IMR by filling out an application.
2. Agree and provide written consent to participate in an IMR.
3. The CDI will determine if the request is eligible for an IMR.
4. The IMR Organization will have 30 days to review once all information is gathered unless the request involves an imminent and serious threat to health, which can be expedited and a decision rendered in 3 days.
5. The IMR organization will send the decision to You, Guardian and the Insurance Commissioner.
6. The Commissioner will adopt the recommendation of the IMR organization and promptly notify You and Guardian. The decision is binding to Guardian.

B400.3340

All Options

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

All Options

**Vision Service Plan (VSP) -
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 VSP, 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 VSP Preferred Providers in his or her area.

A Covered Person may receive vision services from any VSP Preferred Provider. If a Preferred Provider ends his or her relationship with VSP for any reason, VSP will be responsible for furnishing vision services to Covered Persons either through that provider or another VSP 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 VSP should he or she have any questions about the vision coverage.

VSP Customer Care

877-814-8970

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 VSP 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.

B435.0989

All Options

Continuity Of Care

At Your request, We can arrange for the completion of covered services by a terminated Preferred Provider for the duration of an Acute Condition. A terminated Preferred Provider means a vision care practitioner whose contract to provide services to Covered Persons is terminated or not renewed by Us or one of Our contracting vision groups. A terminated Preferred Provider is not a vision care practitioner who voluntarily leaves Us or Our contracting vision group. You must be undergoing a course of treatment for an Acute Condition and Your coverage under the Policy must continue during the completion of covered services.

B435.0511

All Options

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 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 VSP. See Obtaining Services from a Preferred Provider. If authorization is not received, benefits will be paid as if services and supplies were received from a Non-Preferred Provider.

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

Copayments: A Covered Person must pay a Copayment for the first service provided (either a vision examination or Vision Materials), if provided at the same time. 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 the 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.

B435.1312

All Options

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

All Options

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 \$39.00.

B435.0049

All Options

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, except for Contact Lens benefit.

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

B435.0060

All Options

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, Polycarbonate Lenses.

B435.0578

All Options

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

B435.0583

All Options

If a Covered Person uses a Non-Preferred Provider, We limit what We pay to: (1) \$23.00 for each pair of single vision lenses; (2) \$37.00 for each pair of bifocal lenses; (3) \$49.00 for each pair of trifocal lenses; and (4) \$64.00 for each pair of Lenticular Lenses.

B435.0590

All Options

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

B435.0597

All Options

Standard Frames: We cover charges for Standard Frames.

If a Covered Person uses a Preferred Provider, We cover charges up to a retail frame allowance of \$130.00.

If a Covered Person uses a Non-Preferred Provider, We limit what we pay for each set of Standard Frames to \$46.00.

We only cover charges for one set of Standard Frames in any two calendar year Benefit Period.

If the Covered Person chooses elective contact lenses, We do not cover Standard Frames for two calendar years from the date the elective contact lenses are purchased.

B435.0713

All Options

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 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 or Keratoconus.

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.

B435.0616

All Options

Elective Contact Lenses: We cover charges for elective 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 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 and Standard Frames for two calendar years from the date the elective contact lenses are purchased.

If a Covered Person uses a Preferred Provider, We limit what We pay for elective contact lenses to \$130.00

If a Covered Person uses a Non-Preferred Provider, We limit what We pay for elective contact lenses to \$100.00.

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

B435.1114

All Options

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 \$125.00 per test.

We cover no more than two Low Vision Supplementary Test(s) per Covered Person in any 24 month Benefit Period.

We limit what We pay for all covered Low Vision services, including any amount paid for Low Vision Supplementary Testing, to \$1,000.00 per Covered Person in any 24 month Benefit Period.

B435.1126

All Options

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 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.
- Benefits cannot be split. Frames and lenses must be purchased during the same office visit.

B435.1337

All Options

- Progressive Multi-Focal Lenses.

B435.0089

All Options

- Anti-Reflective Coating of the lens or lenses.

B435.0090

All Options

- Photochromic Lenses.

B435.0092

All Options

- Ultraviolet Coating of lenses.

B435.0093

All Options

- Scratch Resistant Coating.

B435.0095

All Options

- High Index Lenses.

B435.0096

All Options

- Polycarbonate Lenses for adults.

B435.0097

All Options

- Polarized/Laminated Lenses.

B435.0098

All Options

- Oversize Lenses.

B435.0636

All Options

- Mirror and Ski Coating.

B435.0099

All Options

- Edge Treatment.

B435.0100

All Options

- Tinted Lenses.

B435.0637

All Options

- Blended Lenses.

B435.0101

All Options

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.

B435.0147

All Options

DEFINITIONS

This section defines certain terms appearing in Your Certificate.

B040.0004

All Options

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing 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.

B435.0518

All Options

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

B435.0516

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

B435.0185

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

B435.0115

All Options

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

B435.0116

All Options

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

B040.0856

All Options

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

All Options

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 20 hours per week), at:

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

B435.0146

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

All Options

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

B435.1047

All Options

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

All Options

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

All Options

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

B435.0692

All Options

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

All Options

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

B040.0866

All Options

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

B435.0128

All Options

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

B435.0129

All Options

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

B040.0870

All Options

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

All Options

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

B435.0131

All Options

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

B435.0132

All Options

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

All Options

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

B435.0638

All Options

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

B435.0135

All Options

Qualified Retiree: This term means Qualified Retirees are covered as outlined in Your company's benefit provisions. Please see your Plan Administrator for details.

B040.0875

All Options

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

All Options

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

All Options

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

B435.0136

All Options

Spouse: This term means the person to whom You are legally married, or Your registered domestic partner, civil union partner or equivalent as recognized and allowed by federal law, or state law in Your state of residence or the state in which the marriage or Your registered domestic partner, civil union partner or equivalent was recorded.

B435.0517

All Options

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

B435.0639

All Options

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

B435.0139

All Options

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

B040.0878

All Options

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

B435.0141

All Options

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

All Options

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

B435.0143

All Options

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

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

Assistance with Questions

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

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.

B435.0148

All Options

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

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

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

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

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

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

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

Appeal of Adverse Benefit Determinations If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal. Guardian will conduct a full and fair review of an appeal which includes providing to claimant(s) the following:

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

B435.0149

All Options

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

All Options

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

All Options

Group Enrollment Period A group enrollment period is held each year from May 1st to June 30th. 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

All Options

PPO Copayments First Service Provided none
Low Vision Examinations and Services None
Low Vision Materials None

Non-PPO Cash Deductibles First Service Provided none
Low Vision Examinations and Services None
Low Vision Materials None

Payment Rates For Covered Charges 100%
For Low Vision Supplementary Testing furnished by a Preferred Provider 100%
For Low Vision Supplementary Testing furnished by a Non-Preferred Provider 100%
For Low Vision Supplementary Care furnished by a Preferred Provider 75%
For Low Vision Supplementary Care furnished by a Non-Preferred Provider 75%

B435.1136

All Options

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

All Options

CERTIFICATE RIDER

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

Services and Supplies Received from Participating Retail Chain Providers

Vision care services and supplies that are covered by the Certificate when received from a Preferred Provider or a Non-Preferred Provider may also be covered by the Certificate when such services and supplies are received from a Participating Retail Chain Provider, subject to the limitations and exclusions below.

If services and supplies are received from a Participating Retail Chain Provider, We pay benefits for covered charges, after the Copayment, as shown below:

SERVICES AND SUPPLIES	PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM’S CLUB	OTHER PARTICIPATING RETAIL CHAIN PROVIDERS
Eye Exam - one in any one calendar year Benefit Period.	Covered In Full.	Covered In Full.

B435.1387

All Options

Standard Lenses - one pair in any one calendar year Benefit Period.

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

B435.0668

All Options

SERVICES AND SUPPLIES

PARTICIPATING RETAIL CHAIN PROVIDER - COSTCO, WALMART and SAM'S CLUB

OTHER PARTICIPATING RETAIL CHAIN PROVIDERS

Standard Frames - one set in any 2 calendar year Benefit Period.

Covered In Full up to \$70.00. No discount available on charges in excess of the benefit amount.

Covered In Full up to \$130.00.

B435.1388

All Options

Elective Contact Lenses - one pair in any one calendar year Benefit Period.

- Contact Lens (Materials Only)

Covered In Full up to \$130.00.

Covered In Full up to \$130.00.

B435.0672

All Options

LIMITATIONS

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

B435.1160

All Options

EXCLUSIONS

- We do not cover charges for:
 - Medically Necessary Contact Lenses.
 - Safety Glasses.
 - Interim Benefits.
 - Primary Eye Care.
 - Diabetic Eye Care Plus Program.

B435.1161

All Options

DEFINITIONS

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

Participating Retail Chain Provider: This term means vision care providers who are not contracted as VSP Preferred Providers but who have agreed to bill VSP directly for covered vision services and supplies provided as set forth in this rider. Not all Participating Retail Chain Providers may be able to provide all such covered vision services and supplies. Covered Persons should discuss requested services with their provider or contact VSP Customer Care at (877) 814-8970 for details.

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

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 or a Participating Retail Chain Provider at the time covered vision services or supplies are received.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B435.0691

AMENDATORY RIDER

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

The definition of **Spouse** is replaced with the following:

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

Domestic Partner: The same-sex or different-sex person with whom You have registered Your relationship with any state or local governmental domestic partner registry. **Domestic Partners** are not subject to any proof of relationship or waiting period requirements that are not also imposed upon marriages. A **Domestic Partner** registry certificate will be accepted as fully equivalent to a marriage certificate. Similarly, a dissolution of domestic partnership notice will be accepted as fully equivalent to a divorce decree.

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

The Guardian Life Insurance Company of America



Michael Prestileo, Senior Vice President

B601.0246

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