
**YOUR
GROUP INSURANCE
PLAN**

**NOVOGRADAC & COMPANY LLP
CLASS 0002
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

B999.0042

This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".

EVIDENCE OF COVERAGE

This evidence of coverage verifies that the employee named below is covered by the Plan Sponsor for the benefits described in this booklet, provided the eligibility and enrollment requirements are met.

Plan No.	Evidence No.	Effective Date
Issued To		

This EVIDENCE OF COVERAGE replaces any EVIDENCE OF COVERAGE previously issued under the above Plan which describes similar or identical benefits provided by the Plan Sponsor.

B110.0051

TABLE OF CONTENTS

IMPORTANT NOTICE	
An Important Notice About Continuation Rights	2
YOUR CONTINUATION RIGHTS	
Federal Continuation Rights	3
Uniformed Services Continuation Rights	7
ELIGIBILITY FOR DENTAL COVERAGE	
Employee Coverage	8
Your Right To Continue Group Coverage During A Family Leave Of Absence	9
Dependent Coverage	11
CERTIFICATE AMENDMENT	15
DENTAL HIGHLIGHTS	17
DENTAL EXPENSE INSURANCE	
Covered Charges	18
Alternate Treatment	19
Proof Of Claim	19
Pre-Treatment Review	19
Benefits From Other Sources	20
The Benefit Provision - Qualifying For Benefits	20
After This Insurance Ends	22
Special Limitations	22
Exclusions	23
List of Covered Dental Services	25
Group I - Preventive Dental Services	26
Group II - Basic Dental Services	27
Group III - Major Dental Services	33
CERTIFICATE AMENDATORY RIDER	36
Timely Access to Care	36
Continuity Of Care	37
Continuing Coverage Past the Child Age Limit	38
COORDINATION OF BENEFITS	
Definitions	39
Order Of Benefit Determination	41
Effect On The Benefits Of This Plan	43
Right To Receive And Release Needed Information	43
Facility Of Payment	43
Right Of Recovery	44
CERTIFICATE AMENDMENT	45
SUBROGATION AND RIGHT OF RECOVERY	46
GLOSSARY	49

TABLE OF CONTENTS (CONT.)

STATEMENT OF ERISA RIGHTS

- The Guardian's Responsibilities 56
- Group Health Benefits Claims Procedure 57
- Termination of This Group Plan 61

IMPORTANT NOTICE

These benefits are directly funded through and provided by your employer, and are not insured by Guardian. Guardian supplies administrative services, such as: claims services and preparation of employee benefit booklets.

Your employer, has the sole responsibility and liability for payment of these benefits.

As used in this booklet, the terms:

- "certificate" refers to this booklet describing the benefits directly funded through and provided by your employer;
- "insurance" and "insured" refers to the benefits directly funded through and provided by your employer;
- "plan", "we", "us" and "our" refer to the benefits that are directly funded through and provided by your employer, and are not insured by Guardian;
- "premium," "premiums," and "premium charge" refer to payments required from you for coverage under this plan; and
- "proof of insurability" refers to any evidence of your good health which may be required under this plan.

All terms and provisions, maximums or limitations set forth in this booklet will be applicable to these benefits provided by your employer.

B115.0126

An Important Notice About Continuation Rights

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

B235.0109

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

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

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

This section does not apply to any coverage for loss of income due to disability. This coverage can not be continued under this section.

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

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

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

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

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

Federal Continuation Rights (Cont.)

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

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

B235.0577

All Options

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

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

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

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

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

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

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

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

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

B235.0181

All Options

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

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

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

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

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

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

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of a covered dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;
- (5) the end of the period for which the last payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

B235.0190

Uniformed Services Continuation Rights

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

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

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

B235.0194

ELIGIBILITY FOR DENTAL COVERAGE

B489.0002

Employee Coverage

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

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

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

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

B489.0122

When Your Coverage Starts *Employee* benefits are scheduled to start on your effective date.

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

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

B489.0070

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

Your coverage ends on the date you die.

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

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

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

B489.0075

All Options

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

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

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

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

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

Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

- The end of the period for which the premium has been paid.

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

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

Coverage During a Temporary Leave If your active full-time service ends because you are disabled by pregnancy, childbirth or a related medical condition you may continue your coverage for up to four months during any twelve consecutive months.

Your employer may recover from you any premium paid if: 1) you fail to return from leave after four months; and 2) your failure to return is for a reason other than one of the following: (a) your taking leave under the Moore-Brown-Roberti Family Rights Act; (b) the continuation, recurrence, or onset of a health condition that entitles you to leave is beyond your control; or (c) if your employer is a state agency, the collective bargaining agreement will govern.

B489.0628

All Options

Dependent Coverage

B200.0271

All Options

Eligible Dependents For Dependent Dental Benefits Your *eligible dependents* are: (a) your legal spouse; (b) your dependent children who are under age 26.

B489.0460

All Options

Adopted Children And Step-Children Your "dependent children" include your legally adopted children and, your step-children.

We treat a child as legally adopted from the time the child is placed in your physical custody for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued. We cover your adopted child from the moment of his or her placement if you are already covered for dependent child coverage when the child is placed for adoption. If you do not have dependent coverage when the child is placed for adoption, we cover the child for the first 31 days from the moment of his or her placement. To continue the child's coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date of placement. If you fail to do this, the child's coverage will end at the end of the 31 days. The child won't be covered by this plan again until you enroll the child. Then the child will be covered as of the date you sign the enrollment form and will be a late entrant and subject to any applicable late entrant penalties.

If this plan has pre-existing restrictions, they will not apply to a minor child adopted by you after this plan starts.

Dependents Not Eligible We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

B489.0499

All Options

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

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

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

The child's coverage ends when yours does.

B449.0042

All Options

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

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

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

B200.0749

All Options

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

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

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

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

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

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

B489.0254

All Options

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

B200.0692

All Options

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

B489.0232

All Options

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

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

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

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this coverage's age limit. It happens to a spouse on the last day of the month in which a marriage ends in legal divorce or annulment.

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

B489.0465

CERTIFICATE AMENDMENT

Effective October 1, 2009, this rider amends the dependent coverage provisions as follows:

Your domestic partner will be eligible for coverage under this plan subject to all of the terms of this plan and the limitations below. "Domestic partner" means an adult who has chosen to share his or her life with you in an intimate and committed relationship of mutual caring.

To qualify for such coverage, you and your domestic partner must be either:

- (a) registered domestic partners; or
- (b) non-registered domestic partners.

As used here:

"Registered domestic partners" means an employee and his or her domestic partner who: (a) have filed a Declaration of Domestic Partnership with the California Secretary of State; (b) were registered as a domestic partner in the registry for those partnerships; and (c) were issued a copy of the registered form and a Certificate of Registered Domestic Partnership.

"Non-registered domestic partners" means an employee and his or her domestic partner who:

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

Certificate Amendment (Cont.)

- i. granting each other health care powers of attorney;
- j. designation of each other as beneficiary under a retirement benefit account; or
- k. evidence of other joint financial responsibility.

Your registered domestic partner, or non-registered domestic partner, will be eligible for dental coverage under this plan.

To cover your non-registered domestic partner, you must complete a "Declaration of Domestic Partnership" attesting to the relationship and forward it to us.

A registered or non-registered domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were your dependent children.

Coverage for a registered domestic partner and his or her dependent children ends when the domestic partnership is dissolved as provided under California law.

Coverage for a non-registered domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a non-registered domestic partner as described above. Upon termination of a non-registered domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once you submit a "Statement of Termination", you may not enroll another non-registered domestic partner for a period of 12 months from the date of the previous termination.

A non-registered domestic partner and his or her children will not be eligible for:

- (a) survivor benefits upon your death as explained under the "When Dependent' Coverage Ends" section;
- (b) continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless you are also eligible for and elect continuation.

A registered domestic partner will have all of the rights of a spouse under this plan except that the continuation of dental coverage as explained under the "Federal Continuation Rights" section is available to a registered domestic partner and his or her children only if you are also eligible for and elect continuation.

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

B489.0223

All Options

DENTAL HIGHLIGHTS

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

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

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

B497.0075

All Options

● **Payment Rates:**

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

B497.0087

All Options

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

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

B497.0104

All Options

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

B497.2407

DENTAL EXPENSE INSURANCE

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

B498.0007

Covered Charges

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

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

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

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

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

B498.0070

All Options

Alternate Treatment

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

Proof Of Claim

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

B498.1141

All Options

Pre-Treatment Review

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

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

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

Pre-Treatment Review (Cont.)

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

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

B498.0004

All Options

Benefits From Other Sources

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

B498.0005

All Options

The Benefit Provision - Qualifying For Benefits

B498.0072

All Options

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

- All Group II Services.

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

- All Group III Services.

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

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

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

B498.0232

All Options

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

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

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

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

B498.0187

All Options

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

B498.0192

All Options

**Non-Orthodontic
Family Deductible
Limit**

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

B498.0073

All Options

Payment Rates

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

- Benefits for Group I Services 100%
- Benefits for Group II Services 80%
- Benefits for Group III Services 50%

B498.0082

All Options

After This Insurance Ends

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

B498.0234

All Options

Special Limitations

B498.0138

All Options

Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan A *covered person* may have one or more congenitally missing teeth or may have had one or more teeth lost or extracted before he or she became covered by this *plan*. We won't pay for a *dental prosthesis* which replaces such teeth unless the *dental prosthesis* also replaces one or more eligible natural teeth lost or extracted after the *covered person* became covered by this *plan*.

B498.0133

All Options

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

- **Teeth Extracted While Insured By The Prior Plan** - The "Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan" provision above, does not apply to a *covered person's dental prosthesis* which replaces teeth: (a) that were extracted while the *covered person* was insured by the *prior plan*; and (b) for which extraction benefits were paid by the *prior plan*.
- **Deductible Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's* deductibles required under this *plan*, by the amount of covered charges applied against the *prior plan's* deductible. The *covered person* must give us proof of the amount of the *prior plan's* deductible which he or she has satisfied.
- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first *benefit year* of this *plan*, we reduce a *covered person's benefit year payment limits* by the amounts paid or payable under the *prior plan*. The *covered person* must give us proof of the amounts applied toward the *prior plan's* payment limits.

B498.0131

All Options

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan*.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.
- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or *appliance* or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment*; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

Exclusions (Cont.)

- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this *plan*.
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment*.
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis*; or the fabrication of a spare *appliance* or *dental prosthesis*.
- Prescription medication.
- Desensitizing medicaments; and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Pulp vitality tests; or caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances*. But, this does not include interim partial dentures/stayplates to replace *anterior teeth* extracted while insured under this *plan*.
- Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a *dental prosthesis*; and (2) odontoplasty.
- Replacing an existing appliance or *dental prosthesis* with any *appliance* or prosthesis, unless it is: (1) at least 5 years old and is no longer usable; or (2) damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can not be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.

Exclusions (Cont.)

- The replacement of extracted or missing third molars/wisdom teeth.
- Treatment of congenital or developmental malformations; or the replacement of congenitally missing teeth
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment.*

B498.2181

All Options

List of Covered Dental Services

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

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

B490.0148

All Options

Group I - Preventive Dental Services
(Non-Orthodontic)

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

- Adult prophylaxis covered age 12 and older.

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

Fluoride treatment, topical application - limited to 1 treatment(s) in any 6 consecutive month period.

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

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

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

B498.4803

All Options

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

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

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

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

B498.0164

All Options

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

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

Other diagnostic radiographs:

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

Intraoral periapical or occlusal films - single films

B498.0165

All Options

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

B498.3461

All Options

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

B498.0166

All Options

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic Services Allowance includes examination and diagnosis.

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

Group II - Basic Dental Services (Cont.)
(Non-Orthodontic)

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

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

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic. Restorations on *anterior teeth* that do not involve the incisal edge are considered a single surface filling.

Silicate cement, per restoration
Composite resin

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

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

B498.1145

All Options

Crown And Prosthodontic Restorative Services Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

Group II - Basic Dental Services (Cont.)
(Non-Orthodontic)

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

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

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

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

B498.1122

All Options

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

Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.

Pulp capping, direct

Pulp capping, indirect - includes sedative filling.

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

Gross pulpal debridement

Pulpal therapy, limited to primary teeth only

Root Canal Treatment

Root canal therapy

Root canal retreatment, limited to once per tooth, per lifetime

Treatment of root canal obstruction, no-surgical access

Incomplete endodontic therapy, inoperable or fractured tooth

Internal root repair of perforation defects

Other Endodontic Services

Apexification, limited to a maximum of three visits

Apicoectomy, limited to once per root, per lifetime

Root amputation, limited to once per root, per lifetime

Retrograde filling, limited to once per root, per lifetime

Hemisection, including any root removal, once per tooth

B498.0201

All Options

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

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

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

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

B498.0202

All Options

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

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

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

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

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

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

Group II - Basic Dental Services (Cont.)
(Non-Orthodontic)

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

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

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

Periodontal surgery related

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

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

B498.0203

All Options

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

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

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

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

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

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

B498.1124

All Options

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

Injectable antibiotics needed solely for treatment of a dental condition.

B498.0206

Group III - Major Dental Services
(Non-Orthodontic)

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

Single Crowns

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

Inlays

- Onlays, including inlay
- Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

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

Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.

- Abutment supported crown
- Implant supported crown
- Abutment supported retainer for fixed partial denture
- Implant supported retainer for fixed partial denture
- Implant/abutment supported removable denture for completely edentulous arch
- Implant/abutment supported removable denture for partially edentulous arch
- Implant/abutment supported fixed denture for completely edentulous arch
- Implant/abutment supported fixed denture for partially edentulous arch
- Dental implant supported connecting bar
- Prefabricated abutment
- Custom abutment

Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

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

Surgical placement of implant body, endosteal implant

Surgical placement, eposteal implant

Surgical placement, transosteal implant

Other Implant services

Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime

Radiographic/surgical implant index - limited to once per arch in any 24 month period

Repair implant supported prosthesis

Repair implant abutment

Implant removal

B498.1148

All Options

Prosthodontic Services Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

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

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

Bridge Pontics

Resin with metal

Porcelain

Porcelain with metal

Full cast metal

3/4 cast metal crowns

3/4 porcelain crowns

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

B498.1146

CERTIFICATE AMENDATORY RIDER

This Rider amends the Certificate as follows and for plans issued before 07/01/2017, is effective on the first Policy Anniversary following 07/01/2017. For plans issued after 07/01/2017, the rider is effective on the Policy Date.

The provision, **Timely Access to Care** is added:

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of a *covered person's* condition consistent with good professional dental practice.

Guardian's *dental preferred provider organization (PPO)* has adequate capacity and availability of *preferred providers* to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

- Urgent appointments to be offered within 72 hours of the time of request for an appointment when consistent with the nature of a *covered person's* condition and as required by professionally recognized standards of dental practice.
- Non-urgent appointments (initial/routine) to be offered within 36 business days of the request for an appointment.
- Preventive dental care appointments to be offered within 40 business days of the request for an appointment.

The Timely Access to Care appointment wait time standards may not apply if a *covered person* is requesting a specific date and time. The applicable waiting time for a particular appointment may also be longer if the referring or treating *dentist*, acting within the scope of the *dentist's* practice and consistent with professionally recognized standards of dental practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on a *covered person's* health.

When it is necessary for a *covered person's dentist* or a *covered person* to reschedule an appointment, the appointment will be promptly rescheduled by a *covered person's dentist* in a manner that is:

- Appropriate for a covered person's dental care needs;
- Ensures continuity of care consistent with good professional dental practices; and
- Meets California's standards regarding the accessibility of dental services in a timely manner.

Language and interpreter services are available for a *covered person* at no cost. Interpreter services, if requested, must be coordinated with scheduled appointments in a manner that ensures interpreter services are provided at the time of the appointment, consistent with California standards, without imposing a delay in scheduling.

Preferred providers are required to have an answering service or a telephone answering machine during non-business hours. Their message must provide instructions regarding how a *covered person* may obtain urgent or emergency care, including how to contact another *dentist* who has agreed to be on-call to triage or screen by phone, or, if needed, deliver urgent or emergency care. If the *preferred provider* does not answer and a *covered person* has an emergency, a *covered person* may call 911 or go to the nearest hospital. Emergency/urgent services may be received by any *dentist*.

Telephone triage or screening services are to be provided in a timely manner appropriate for a *covered person's* condition. During normal business hours the waiting time for a *covered person* to speak by telephone with a knowledgeable and competent customer service representative regarding a *covered person's* questions and concerns will not exceed 10 minutes.

If a *covered person* has any questions or want to request an interpreter, please call Our Customer Response Unit at 1-800-541-7846 or the toll-free number on the *covered person's* ID card.

The provision, **Continuity Of Care** is added:

Continuity Of Care

At a *covered person's* request, we can arrange for the completion of covered services by a terminated *dentist* for the duration of an acute condition. A terminated *dentist* means a *dentist* whose contract to provide services to *covered persons* is terminated or not renewed by us or one of our contracting dental groups. A terminated *dentist* is not a *dentist* who voluntarily leaves us or our contracting dental group. A *covered person* must be undergoing a course of treatment for an acute condition and the *covered person's* coverage under the Policy must continue during the completion of covered services.

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

This Rider amends the Policy regarding the term "**spouse**" as follows:

Reference to the term "spouse" within the contract, 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.

The **Eligible Dependents For Dependent Dental Benefits** provision is revised with the following:

Your *eligible dependents* are: (a) your spouse; and (b) your dependent children including:

- A newborn child, natural child, stepchild or a child placed with you for adoption or foster care who is under age 26.

The **Handicapped Children** provision is replaced in its entirety with the following:

Continuing Coverage Past the Child Age Limit

A child who is incapable of self-support because of a physically or mentally disabling injury, illness or condition. A dependent child may remain eligible for dependent benefits past the age limit, subject to the conditions below:

- The condition started before he or she reached the age limit; and
- The child remained continuously covered until he or she reached the age limit; and
- We will send notice to you at least 90 days prior to the limiting age and you must send us written proof that the child is dependent upon you for support and maintenance as is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. You have 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the child's eligibility is made. We can ask for periodic proof that the child's condition continues, but we cannot ask for this proof more than once a year after the two-year period following the child's attainment of the limiting age.

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

The Guardian Life Insurance Company of America



Michael Estep, Vice President

B531.0825

COORDINATION OF BENEFITS

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

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

Definitions

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

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

- (1) If a person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room is **not** an allowable expense. This does not apply if: (a) the stay in the private room is medically necessary in terms of generally accepted medical practice; or (b) one of the plans routinely provides coverage for private hospital rooms.
- (2) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are: (a) precertification of admissions and procedures; (b) continued stay reviews; and (c) preferred provider arrangements.
- (3) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan's reasonable and customary charges for a specific benefit is **not** an allowable expense.
- (4) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan's negotiated fees for a specific benefit is **not** an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangements will be the allowable expense for all plans.

Definitions (Cont.)

- Claim** This term means a request that benefits of a plan be provided or paid.
- Claim Determination Period** This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.
- Closed Panel Plan** This term means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), or other plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan; and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.
- Coordination Of Benefits** This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
- Custodial Parent** This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.
- Group-Type Contracts** This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.
- Hospital Indemnity Benefits** This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance; (2) closed panel or other forms of group or group-type coverage, whether insured or uninsured; (3) group-type contracts; (4) amounts of group or group-type hospital indemnity benefits in excess of \$200.00 per day; (5) medical components of group long-term care contracts such as skilled nursing care; (6) medical benefits under group or individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.
- This term does not include: (a) individual or family insurance; (b) closed panel or other individual coverage, except for group-type coverage; (c) amounts of group or group-type hospital indemnity benefits of \$200.00 or less per day; (d) school accident type coverage; (e) benefits for non-medical components of group long-term care policies; or (f) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.
- This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Definitions (Cont.)

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

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

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

This Plan This term means the group health benefits provided under this group plan.

B550.0087

All Options

Order Of Benefit Determination

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

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

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

This Plan **always** pays secondary to any motor vehicle policy available to a covered person, including any medpay, PIP, No Fault or any plan or program which is required by law. All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the rules that applies is the rule to use.

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

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

Order Of Benefit Determination (Cont.)

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

- (1) If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide health care coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.
- (2) If the specific terms of a court decree state that one of the parents must provide health care coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.
- (3) In the absence of a court decree, if the parents are not married, or are separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; (c) the plan of the noncustodial parent; and (d) the plan of the spouse of the noncustodial parent.

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

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

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

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

B550.0088

Effect On The Benefits Of This Plan

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

When This Plan Is Secondary When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses.

Closed Panel Plans If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan will pay or provide benefits as if it were primary when a covered person uses a non-panel provider; except for emergency services or authorized referrals that are paid or provided by the primary plan.

A person may be covered by two or more closed panel plans. If, for any reason including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan, coordination of benefits will not apply between that plan and other closed panel plans.

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

B550.0089

CERTIFICATE AMENDMENT

Notwithstanding any provision in the Plan to the contrary, it is hereby agreed that the Group Plan is amended October 1, 2009 so that,

- (A) A Covered Person may select any holder of a license issued under Section 2135, 1000, 1634 or 2948 of the California Business and Professions Code, to perform any Covered service such holder is expressly authorized by law to perform.
- (B) A Covered Person may select a clinical social worker who is the holder of a license issued under Section 9040 of the California Business and Professions Code, to perform any covered service which such social worker is expressly authorized by law to perform, provided such Covered Person is referred to such social worker by a licensed physician or surgeon.
- (C) A Covered Person may select an occupational therapist, regulated under Section 2570 of the California Business and Professions Code to perform any covered service which such Occupational Therapist is expressly authorized by law to perform, provided such Covered Person is referred to such occupational therapist by a licensed physician or surgeon.
- (D) A Covered Person may select a speech pathologist or audiologist, licensed under section 2530 of the California Business and Professions Code, to perform any covered service which such speech pathologist or audiologist is expressly authorized by law to perform, provided such Covered Person is referred to such speech pathologist of audiologist by a licensed physician or surgeon.
- (E) A Covered Person may select a marriage, family, and child counselor, licensed under Section 17805 of the California Business and Professions Code, to perform any covered service which such family, marriage, and child counselor is expressly authorized by law to perform, provided Covered Person is referred to such family, marriage, and child counselor by a licensed physician or surgeon.

This Rider shall form a part of the Policy, Except as stated in this Rider, nothing contained herein shall be held to alter or affect any of the provisions of the policy, including any prior Riders, Amendments, or Endorsements.

All terms and conditions of your certificate, not specifically changed herein, remain in full force and effect.

B590.9027

SUBROGATION AND RIGHT OF RECOVERY

Notice This section applies to any health care or loss of earnings benefits under this plan.

Purpose When a covered person has the right to recover amounts paid by this plan for health care or loss of earnings benefits, this plan also has certain rights. These are explained below.

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

- **Covered Person:** This term means any employee or dependent on whose behalf this plan pays health care or loss of earnings benefits. It includes the parent or guardian of any such covered employee or dependent who is a minor or incompetent.
- **Health Care:** This term means any: (a) major medical; (b) prescription drug; (c) dental; or (d) vision benefits.
- **Insurance Coverage:** This term means any insurance which provides coverage for: (a) medical expense payments; or (b) liability. This includes, but is not limited to: (i) uninsured motorist coverage; (ii) underinsured motorist coverage; (iii) personal umbrella coverage; (iv) medical payments coverage; (v) workers compensation coverage; (vi) no-fault automobile insurance coverage; or (vii) any first party insurance.
- **Third Party:** This term means any party actually, possibly, or potentially responsible for making any payment to a covered person due to the covered person's injury, sickness or condition. This term also means such party's: (a) the liability insurer; or (b) any insurance coverage. But, this term does not mean: (i) this plan; or (ii) the covered person.

Subrogation When this plan pays a benefit, it will immediately be subrogated to the covered person's rights of recovery from any third party to the full extent of benefits paid.

Recovery If a covered person receives a payment from any third party or insurance coverage due to an injury, sickness or condition, this plan has the right to recover from, and be repaid by, the covered person for all amounts this plan has paid and will pay due to that injury, sickness or condition, from such payment, up to and including the full amount he or she receives from any third party or insurance coverage.

Constructive Trust The covered person must serve as a constructive trustee over the funds that constitute payment from any third party or insurance coverage due to his or her injury, sickness or condition. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. If the covered person fails to hold such funds in trust, it will be deemed a breach of his or her fiduciary duty to the plan.

Lien Rights This plan will have a lien to the extent of benefits this plan paid due to the covered person's injury, sickness or condition for which the third party is liable. The lien will be imposed on any recovery, whether by settlement, judgement, or otherwise, including from any insurance coverage, that a covered person receives due to his or her injury, sickness or condition. The lien may be enforced against any party who holds funds or proceeds which represent the amount of benefits paid by this plan. This includes, but is not limited to: (a) the covered person; (b) the covered person's representative or agent; (c) the third party; (d) the third party's insurer, representative or agent; and (e) any other source who holds such funds.

First Priority Claim This plan's recovery rights are a first priority claim against all third parties or insurance coverage and are to be paid to the plan before any other claim for the covered person's damages. This is the case whether the payment of benefits from the plan is: (a) made to the covered person; or (b) made on his or her behalf to any provider. This plan will be entitled to full repayment on a first dollar basis from any third party's or insurance coverage's payments, even if such payment to the plan will result in a recovery to the covered person which is not sufficient: (i) to make him or her whole; or (ii) to compensate him or her in part or in whole for the damages sustained. This plan is not required to participate in or pay court costs or attorney fees to the attorney hired by the covered person to pursue his or her damage claim.

Applicable To All Settlements And Judgements This plan is entitled to full recovery regardless of whether: (a) any liability for payment is admitted by a third party; or (b) the settlement or judgement received by the covered person identifies the benefits the plan paid. This plan is entitled to recover from any and all settlements or judgements, even those designated as: (i) pain and suffering; or (ii) non-economic damages only.

Cooperation The covered person must fully cooperate with this plan's efforts to recover the benefits it paid. He or she must notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of his or her intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, sickness or condition sustained by him or her. He or she, and his or her agents, must provide all information requested by the plan or its representative. This includes, but is not limited to, completing and submitting any applications or other forms or statements as the plan or its representative may reasonably request. Failure to do this may result in the termination of benefits or the instigation of legal action against him or her.

The covered person must do nothing: (a) to prejudice this plan's rights as described in this section; or (b) to prejudice the plan's ability to enforce the terms of this section. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full amount of all benefits paid by this plan. Failure to assist the plan in pursuit of its subrogation rights or failure to reimburse the plan from any settlement or recovery obtained by the covered person may result in the termination of benefits or the instigation of legal action against him or her.

The plan or its representative has the right to conduct an investigation regarding the injury, sickness or condition to identify any third party. The plan reserves the right to notify the third party and his or her agents of this plan's lien. Agents include, but are not limited to: (a) insurance companies; and (b) attorneys.

Interpretation In the event that any claim is made that any part of this section is ambiguous, or questions arise as to the meaning or intent of any of its terms, the plan has the sole authority and discretion to resolve all disputes regarding the interpretation of this section.

Jurisdiction Any legal action or proceeding with respect to this section may be brought in any court of competent jurisdiction as the plan may choose. The covered person must submit to each such jurisdiction and waive whatever rights may correspond to him or her by reason of his or her present or future domicile.

B600.0012

All Options

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

B900.0118

All Options

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

B750.0664

All Options

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

B750.0665

All Options

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

B750.0666

All Options

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

B750.0667

All Options

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

B750.0668

All Options

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

B750.0669

All Options

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

B750.0670

All Options

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

B750.0671

All Options

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

B900.0003

All Options

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

B750.0015

All Options

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

B750.0672

All Options

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

B750.0006

All Options

Employer means NOVOGRADAC & COMPANY LLP .

B900.0051

All Options

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

B900.0004

All Options

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 24 hours per week), at his *employer's* place of business.

B750.0230

All Options

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

B900.0006

All Options

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

B750.0673

All Options

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

B900.0008

All Options

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

B750.0685

All Options

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

B750.0676

All Options

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

B750.0677

All Options

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

B750.0679

All Options

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

B750.0678

All Options

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

B750.0681

All Options

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

B750.0682

All Options

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

B750.0683

All Options

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

All Options

The Guardian's Responsibilities

B800.0048

All Options

The dental expense benefits provided by this plan are funded solely by the employer. The benefits **are not** guaranteed by a policy of insurance issued by Guardian. Guardian does supply administrative services, such as claims services, including the payment of claims, preparation of employee benefit booklets, and changes to such benefit booklets.

B800.0064

All Options

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

B800.0049

Group Health Benefits Claims Procedure

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

Guardian is the Claims Administrator with respect to processing claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims.

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

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

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

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

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

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

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

B800.0081

Termination of This Group Plan

Your *employer* may terminate this group *plan* at any time.

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

B800.0068

This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".

CERTIFICATE OF COVERAGE

The Guardian Life Insurance Company of America

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

The Group Vision Insurance Coverage described in this Certificate is attached to the group Policy effective October 1, 2020. This Certificate replaces any Certificate previously issued under the Policy or under any other plan providing similar or identical benefits issued to the Employee 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: NOVOGRADAC & COMPANY LLP

Group Policy Number: 00449948

Effective Date: October 1, 2020



Michael Estep, Vice President



Harris Oliner, Senior Vice President
and Corporate Secretary

B435.0959

TABLE OF CONTENTS

GENERAL PROVISIONS

Applicable Benefits	2
Limitation of Authority	2
Incontestability	2

CONDITIONS OF ELIGIBILITY FOR GROUP VISION

INSURANCE COVERAGE

Employee Eligibility	3
Dependent Eligibility	4
Eligibility Waiting Period	5
When Coverage Starts	5
Exception to When Coverage Starts	5
Family Status Change	6
When Your Coverage Ends	6
When Your Dependent Coverage Ends	7

CONTINUATION OF COVERAGE

Continuation Rights	8
Uniformed Services Continuation Rights	8
COBRA Continuation Rights	8
Family Medical Leave Of Absence (FMLA)	9
Dependent Survivorship Benefit	9

VISION CLAIM PROVISIONS

Filing A Claim	10
Adverse Benefit Determination	12
Appeal of Adverse Benefit Determinations	12
External Reviews And Independent Medical Reviews	13

VISION EXPENSE BENEFITS

Vision Service Plan (VSP) -	
This Plan's Vision Care Preferred Provider Organization	15
Obtaining Services from a Preferred Provider	16
Continuity Of Care	16
How This Plan Works	16
Covered Services And Supplies	17
Exclusions	20

DEFINITIONS

VISION INSURANCE COVERAGE SCHEDULE OF BENEFITS

CERTIFICATE RIDER

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; 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 September 1st to September 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.

B435.0970

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.GuardianAnytime.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

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

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

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

Payment Limits: Payment limits, durational or monetary, are shown in 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.

B435.1311

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 \$200.00.

Covered Services And Supplies (Cont.)

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

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

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

B435.0714

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 one calendar year from the date the elective contact lenses are purchased.

Covered Services And Supplies (Cont.)

If a Covered Person uses a Preferred Provider, We limit what We pay for elective contact lenses to \$200.00

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.

B435.0627

All Options

Elective Contact Lens Fitting and Evaluation: The Covered Person must pay a Copayment each time he or she receives an elective contact lens Fitting and Evaluation for the covered elective contact lenses. 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.

If a Covered Person uses a Non-Preferred Provider the contact lens allowance is applied towards the cost of the contact lenses and the Fitting and Evaluation.

B435.0635

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 24 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

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).

Statement of Erisa Rights (Cont.)

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

Assistance with Questions

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

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law 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.

Statement of Erisa Rights (Cont.)

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 September 1st to September 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	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Necessary Contact Lenses	\$25.00
	Fitting and Evaluation - Up to	\$60.00
	Low Vision Examinations and Services	None
	Low Vision Materials	None
Non-PPO Cash Deductibles	Examinations	\$10.00
	Standard Frames and/or Standard Lenses	\$25.00
	Necessary Contact Lenses	\$25.00
	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%

B435.1133

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

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

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

Covered In Full up to \$110.00. No discount available on charges in excess of the benefit amount.

OTHER PARTICIPATING RETAIL CHAIN PROVIDERS

Covered In Full up to \$200.00.

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 \$200.00.

Covered In Full up to \$200.00.

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 Estep, Vice President

B435.0691

YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE

www.GuardianAnytime.com

Insured employees and their dependents can access helpful, secure information about their Guardian benefits(s) online at:

GuardianAnytime.com - 24 hours a day, 7 days a week.

Anytime, anywhere you have an internet connection you will be able to:

- Review your benefits
- Look up coverage amounts
- Check the status of a claim
- Print forms and plan materials
- And so much more!

To register, go to www.GuardianAnytime.com

 Guardian