YOUR GROUP INSURANCE PLAN BENEFITS

INSHORE

CLASS 0001

AD&D, DENTAL (MDG/N300) BASIC LIFE, OPTIONAL LIFE, VISION ACCESS

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

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

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

New Mexico Residents
Consumer Complaint Notice

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

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

CCN-2019-NM B999.0042

CERTIFICATE OF COVERAGE

The Guardian
10 Hudson Yards
New York, New York 10001

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

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

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COMPLAINT NOTICE

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

The Guardian Sales Office
801 Parkview Drive North, Suite 100
El Segundo, CA 90245
Telephone: (310) 765-2200
(800) 225-3399
Fax: (310) 765-2040

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

Department of Insurance
300 South Spring St.
Los Angeles, CA 90013

Consumer Hotline: 1-800-927-4357
Website: www.insurance.ca.gov/01-consumers/

CGP-3-CADISC-91 B120.0090

GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this *plan.*

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

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

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

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

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

CGP-3-R-GENPRO-90 B160.0002

Limitation of Authority

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

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

Incontestability

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

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

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

CGP-3-R-INCY-96 B160.0061

Examination and Autopsy

We have the right to have a *doctor* of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. And we have the right to have an autopsy performed in the case of death, where allowed by law. We'll pay for all such examinations and autopsies.

CGP-3-R-EA-90 B160.0006

Accident and Health Claims Provisions

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

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

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

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we're liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

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

Payment of Benefits We'll pay benefits for loss of income once every 30 days for as long as we're liable, provided you submit periodic written proof of loss as stated above. We'll pay all other *accident and health* benefits to which you're entitled as soon as we receive written proof of loss.

We pay all *accident and health* benefits to you, if you're living. If you're not living, we have the right to pay all *accident and health* benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See "Your Accidental Death and Dismemberment Benefits" for how dismemberment benefits are paid.

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

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

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

CGP-3-R-AHC-90 B160.0005

Coordination Between Continuation Sections

A covered person may be eligible to continue his group health benefits under this plan's "Federal Continuation Rights" section and under other continuation sections of this plan at the same time. If he chooses to continue his group health benefits under more than one section, the continuations: (a) start at the same time; (b) run concurrently; and (c) end independently, on their own terms.

A covered person covered under more than one of this plan's continuation sections: (a) will not be entitled to duplicate benefits; and (b) will not be subject to the premium requirements of more than one section at the same time.

CGP-3-R-COC-87 B240.0044

An Important Notice About Continuation Rights

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

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

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice

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

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

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

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

Conversion

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

If Your Group Health Benefits End

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

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

Extra Continuation for Disabled Qualified Continuees

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

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

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

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

CGP-3-R-COBRA-96-1 B235.0631

If You Die While Insured

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

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

If Your Marriage Ends

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

If a Dependent Child Loses Eligibility

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

Concurrent Continuations

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

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

Special Medicare Rule

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

The Qualified Continuee's Responsibilities

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

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

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

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

Your Employer's Responsibilities

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

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

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

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

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

Your Employer's Liability

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

Election of Continuation

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

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

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

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

Grace in Payment of Premiums

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

When Continuation Ends

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

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

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

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

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

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

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

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

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

Uniformed Services Continuation Rights

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

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

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

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

ELIGIBILITY FOR LIFE AND DISMEMBERMENT COVERAGES

B264.0003

Employee Coverage

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

Other Conditions You must:

(a) be legally working in the United States.

(b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 30 hours per week), at:

(i) your *employer's* place of business;

(ii) some place where your *employer's* business requires you to travel; or

(iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

Note: If you are working outside the United States on a temporary assignment and you meet all other conditions of eligibility, you will be covered by this *plan,* provided that: you are on an assignment, not exceeding one year, in a country or region that is not under a travel warning issued by the US Department of State. Coverage may be available when you are: (1) on a longer temporary assignment; or (2) assigned in a region that is under a travel warning; however, coverage must be approved in writing.

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 also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

Part or all of your insurance amounts may be subject to *proof* that you're insurable. The Life Schedule explains if and when we require *proof.* You won't be covered for any amount that requires such *proof* until you give the *proof* to us and we approve it in writing.

If your active *full-time* service ends before you meet any *proof of insurability* requirements that apply to you, you'll still have to meet those requirements if you're later re-employed.

CGP-3-EC-90-1.0 B264.0892

When Your Coverage Starts Employee benefits that don't require *proof* that you are insurable are scheduled to start on your effective date.

Employee benefits that require such *proof* won't start until you send us the *proof* and we approve it in writing. Once we have approved it, the benefits are scheduled to start on the effective date shown in the endorsement section of your application. A copy of the approved application is furnished to you.

But you must be fully capable of performing the major duties of your regular occupation for your *employer* on a full-time basis at 12:01AM Standard Time for your place of residence on the scheduled effective date or dates. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not fully capable of performing the major duties of your occupation on any date part of your insurance is scheduled to start, we will postpone that part of your coverage until the date you are so capable and are working your regular number of hours.

Sometimes, your effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective 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 *plan* replaced.

CGP-3-EC-90-2.0 B264.3210

Delayed Effective Date For Employee Optional Life Coverage

With respect to this *plan's* employee optional group term life insurance, if an *employee* is not actively at work on a *full- time* basis on the date his or her coverage is scheduled to start, due to *sickness* or *injury,* we'll postpone coverage for an otherwise covered loss due to that condition. We'll postpone such coverage until he or she completes 10 consecutive days of active *full-time* service without missing a work day due to the same condition.

Coverage for an otherwise covered loss due to all other conditions will start on the date the *employee* returns to active *full-time* service.

CGP-3-DEF-97 B270.0384

When Your Coverage Ends

Your coverage ends on the date your active *full-time* service ends for any reason. Such reasons include disability, death, retirement, layoff, leave of absence and the end of employment.

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.

It ends on the date you are no longer working in the United States, unless you are on a temporary assignment: (1) not exceeding one year in a country or region that is not under a travel warning by the US Department of State; or (2) for which we have agreed, in writing, to provide coverage.

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. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0 B264.0697

Your Right To Continue Group Life Insurance 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.

Continuation of Coverage

Life and Accidental Death and Dismemberment insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

If Your Group Coverage Would End

Group insurance 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 insurance 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

Insurance may continue until the earliest of the following:

- The date you return to active work.
- In the case of a leave granted to you to care for a covered servicemember: The end of a total leave period of 26 weeks in one 12 month period. This 26 week total leave period applies to all leaves granted to you under this section for all reasons. If you take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case: The end of a total leave period of 12 weeks in any 12 month period.
- The date on which your *Employer's Plan* is terminated or you are no longer eligible for coverage under this *Plan.*
- 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.

GROUP TERM LIFE INSURANCE SCHEDULE

CGP-3-R-SCH-90 B265.0002

Employee Basic Term Life Insurance

CGP-3-R-SCH-90 B265.0003

Your Basic Term Life Insurance Amount

Insurance Amount $5,000.00

CGP-3-R-SCH-90 B265.0011

Employee Basic Accidental Death and Dismemberment Insurance (AD&D)

CGP-3-R-SCH-90 B265.0029

Your Basic AD&D Insurance Amount

Insurance Amount $5,000.00

CGP-3-R-SCH-90 B265.0031

Employee Optional Contributory Term Life Insurance

CGP-3-R-SCH-90 B265.0055

Optional Life Election

You may choose to be insured under the plan of optional term life insurance shown below. You must notify the employer of your election and pay the required premium.

CGP-3-R-SCH-90 B265.0799

Your Optional Term Life Insurance Amount

Plan A

You may elect amounts of optional term life insurance in increments of $10,000.00, but your amount may not be less than $10,000.00 and may not exceed $300,000.00.

CGP-3-R-SCH-90 B265.0063

Reduction of Optional Life Insurance Amount Based on Age

If an employee is less than age 65 when his or her insurance under this plan starts, his or her insurance amount is reduced, on the date he or she reaches age 65, by 35% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 65 but before he or she reaches age 70.

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's optional life insurance amount is reduced, when he or she reaches age 70, by 50% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than $1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0520

Proof of Insurability Requirements

Proof of insurability requirements apply to your optional term life insurance. Such requirements may apply to your full benefit amount or just part of it. When *proof of insurability* requirements apply, it means you must submit to us *proof* that you're insurable, and we must approve your *proof* in writing before your insurance, or the specified part becomes effective.

We require *proof* as follows:

CGP-3-R-SCH-90 B265.0431

We require *proof* before an *employee* switches from his or her current increment of optional term life insurance to an increment which provides a greater amount of insurance.

CGP-3-R-SCH-90 B265.0732

We require *proof* before we will insure any *employee* who enrolls for optional term life insurance after the time allowed for enrolling as specified in this *plan.*

CGP-3-R-SCH-90 B265.0435

We require *proof* for amounts of optional term life insurance in excess of $100,000.00.

CGP-3-R-SCH-90 B265.0437

We require *proof* for amounts of optional term life insurance in excess of $10,000.00, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 65.

CGP-3-R-SCH-90 B265.0697

We require *proof* for all amounts of optional term life insurance, if an *employee*'s scheduled optional term life effective date is after he or she reaches age 70.

CGP-3-R-SCH-90 B265.0702

LIFE INSURANCE

B270.0070

Your Group Term Life Insurance

Basic Life Benefit If you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule.

Proof of Death We'll pay this insurance as soon as we receive written proof of death. This should be sent to us as soon as possible.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your *employer* written notice, unless you've assigned this insurance. But the change won't take effect until your *employer* gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We suggest you speak to your lawyer before you make any assignment. If you decide you want to assign this insurance, ask your *employer* for details or write to us.

Payment to a Minor or Incompetent If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Settlement Option If you or your beneficiary ask us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-LB-90 B270.0113

Portability Privilege

Applicability This provision applies only to this plan's employee Basic group term life insurance. It does not apply to supplemental life insurance, if any is included in this plan. And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction You must provide proof of insurability satisfactory to us.

Portability Of Basic Group Term Life Insurance You may elect to continue all or part of your employee Basic group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this plan ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this plan ends; or (b) are eligible for this plan's Basic Group Term Life Insurance Extended Life Benefit.

You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group plan.

You may port: (a) the full amount(s) of your Basic term life insurance as of the day your coverage under this plan ends, or (b) 50% of such amount, if such amount under this plan is at least $50,000.00.

The Portable Certificate Of Coverage You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits; (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group plan.

The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Basic Life Portability Coverage Premium Notice.

How To Port To get a portable certificate of coverage, you must: (a) apply to us in writing: and (b) pay the required premium. You have 31 days from the date your coverage under this plan ends to do this. We require proof of insurability satisfactory to us.

Defined Term As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95 B270.0326

Your Optional Group Term Life Insurance

Life Benefit Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the plan of benefits you have elected. Your life benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit *proof of insurability* to us, and we approve it in writing. These requirements are also shown in the schedule.

Proof of Death Subject to all of the terms of this *plan,* we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.

Suicide Exclusion We pay no benefits if your death is due to suicide, if such death occurs within two years from your employee optional group term life insurance effective date under this *plan.* Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase.

Seatbelt and Airbag Benefits If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by $10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional $5,000.00, for a total increase of $15,000.00.

Your Beneficiary You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your employer written notice, unless you've assigned this insurance. But the change won't take effect until your employer gives you written confirmation of the change.

If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.

If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.

Assigning Your Life Insurance

If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

We will recognize an assignee as the owner of the rights assigned only if: (a) the assignment is in writing and signed by you; and (b) a signed or certified copy of the written assignment has been received and approved by us.

We will not be responsible for legal, tax or other effects of any assignment, or for any benefits we pay under this *plan* before we receive and approve any assignment.

We suggest you speak to a lawyer before you make any assignment. If you decide you want to assign this insurance, write to us for details.

Payment to a Minor or Incompetent

If your beneficiary is a minor or incompetent, we have the option of paying this insurance in monthly installments. We would pay them to the person who cares for and supports your beneficiary.

Payment of Funeral or Last Illness Expense

We have the option of paying up to $500.00 of this insurance to any person who incurs expenses for your funeral or last illness.

Settlement Option

If you or your beneficiary asks us, we'll pay all or part of this insurance in installments. Any request must be made to us in writing. The amounts of the installments and how they would be paid depend on what we offer at the time the request is made.

CGP-3-R-EOPT-96 B273.0353

Portability Privilege

Applicability

This provision applies only to this *plan's* employee Optional group term life insurance. It does not apply to supplemental life insurance, if any is included in this *plan.* And it does not apply to Accidental Death and Dismemberment Insurance.

Important Restriction

You may not elect a portable certificate of coverage unless you have been covered by this group *plan,* or the one it replaced, for employee Optional group term life insurance for at least three consecutive months prior to the date your coverage under this *plan* ends.

Portability Of Optional Group Term Life Insurance

You may elect to continue all or part of your employee Optional group term life insurance, by choosing a portable certificate of coverage, subject to the following terms.

You may port your coverage if coverage under this *plan* ends because you: (a) have terminated employment; or (b) stop being a member of an eligible class of employees.

You may not port your coverage, if you: (a) have reached your 70th birthday on the day coverage under this *plan* ends; or (b) are eligible for this *plan's* Optional Group Term Life Insurance Extended Life Benefit.

You may not port your coverage if coverage under this plan ends due to: (a) failure to pay any required premium; or (b) the end of this group *plan.*

You may port: (a) the full amount(s) of your Optional term life insurance as of the day your coverage under this *plan* ends, or (b) 50% of such amount, if such amount under this *plan* is at least $50,000.00.

The Portable Certificate Of Coverage

You can port to a portable certificate of coverage. The certificate provides group term insurance. It does not provide any: (a) accidental death and dismemberment benefits: (b) income replacement benefits; or (c) extended life benefits or waiver of premium privileges. The benefits provided by the portable certificate of coverage may not be the same as the benefits of this group *plan.*

The premium for the portable certificate of coverage will be based on: (a) your rate class under this plan; and (b) your age bracket as shown in the Optional Life Portability Coverage Premium Notice.

How To Port

To get a portable certificate of coverage, you must: (a) apply to us in writing; and (b) pay the required premium. You have 31 days from the date your coverage under this *plan* ends to do this. We won't ask for proof that you are insurable.

Defined Term

As used in this provision, the term "port" means to choose a portable certificate of coverage which provides group term life insurance.

CGP-3-R-LP-00 B273.0734

Information About Conversion and Portability

No covered person is allowed to convert his or her coverage, and elect a portable certificate of coverage at the same time. If a situation arises in which a covered person would be eligible to both convert and port, he or she may only exercise one of these privileges. A covered person may never be insured under both a converted policy and a portable certificate of coverage at the same time. The covered person should read his or her plan, as well as any related materials carefully before making an election.

CGP-3-R-LPN-95 B270.0326

THE FOLLOWING PROVISION APPLIES TO YOUR BASIC TERM LIFE INSURANCE:

B275.0076

If Employment or Eligibility Ends

Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy

The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How and When to Convert

To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During the Conversion Period

If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

Notice of Conversion Right

If you are entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA B275.0217

THE FOLLOWING PROVISION APPLIES TO YOUR OPTIONAL GROUP TERM LIFE INSURANCE:

B275.0077

Converting This Group Term Life Insurance

If Employment or Eligibility Ends

Your group life insurance ends if: (a) your employment ends; or (b) you stop being a member of an eligible class of employees. If either happens, you can convert your group life insurance to an individual life insurance policy. Conversion choices are based on your disability status.

If you are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", you can convert to a permanent life insurance policy. You can convert the amount for which you were covered under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy, as explained in the section labeled "Interim Term Insurance". You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

If The Group Plan Ends or Group Life Insurance Is Dropped

Your group life insurance also ends if: (a) this group plan ends; or (b) life insurance is dropped from the group plan for all employees or for your class. If either happens, you may be eligible to convert as explained below. Conversion choices are based on your disability status.

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) $2,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you can convert to: (a) a permanent life insurance policy; or (b) an interim term insurance policy. You can convert the full amount for which you were covered under this plan.

If you are later approved for the Extended Life Benefit, then the converted policy, if any, is cancelled as of our approval date.

The Converted Policy

The premium for the converted policy will be based on your age on the converted policy's effective date. The converted policy will start at the end of the period allowed for conversion. The converted policy does not include disability or dismemberment benefits.

Interim Term Insurance

If you: (a) are disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium"; and (b) have not yet been approved for the Extended Life Benefit, you have the option to convert your coverage to an individual term life insurance policy. The individual term policy requires lower premiums than an individual permanent insurance policy.

This Interim term policy is available for only one year from the date you become disabled. During this year, if you are approved for the Extended Life Benefit, the interim term insurance is cancelled, as of our approval date. If, after one year, you have not been approved for the Extended Life Benefit, you must convert to an individual permanent life insurance policy, or coverage will end. Premiums for the individual permanent life insurance policy will be based on your age as of the date you convert from the interim term insurance policy.

How and When to Convert

To get a converted policy, you must apply to us in writing and pay the required premium. You have 31 days after your group life insurance ends to do this. We won't ask for proof that you are insurable.

Death During the Conversion Period

If you die in the 31 days allowed for conversion, we'll pay your beneficiary the amount you could have converted. We'll pay whether or not you applied for conversion.

Notice of Conversion Right

If you are entitled to obtain a converted policy under this section, full compliance with this provision for Notice of Conversion Right will be satisfied by written notice: (a) given to you by the employer; (b) mailed to you by the employer at your last known address; or (c) mailed to you by us at your last known address that is supplied to us by the employer.

This notice should be given at least 15 days before the end of the 31 day period allowed for conversion as described in "How and When to Convert." If the notice is not given at least 15 days before the end of such period, you will have an additional period of 25 days from the date notice is given to apply for the converted policy and pay the required premium. But, in no event shall the additional period extend more than 60 days beyond the 31 day period allowed for conversion as described above.

CGP-3-R-LCONV-99-CA B275.0218

Your Accelerated Life Benefit

IMPORTANT NOTICE: USE OF THE BENEFIT PROVIDED BY THIS SECTION MAY HAVE TAX IMPLICATIONS AND MAY AFFECT GOVERNMENT BENEFITS OR CREDITORS. YOU SHOULD CONSULT WITH YOUR TAX OR FINANCIAL ADVISOR BEFORE APPLYING FOR THIS BENEFIT.

PLEASE NOTE: THE AMOUNT OF GROUP TERM LIFE INSURANCE IS PERMANENTLY REDUCED BY THE GROSS AMOUNT OF THE ACCELERATED LIFE BENEFIT PAID TO YOU.

Accelerated Life Benefit

If you have a medical condition that is expected to result in your death within 6 months, you may apply for an Accelerated Life Benefit. An Accelerated Life Benefit is a payment of part of your group term life insurance made to you before you die.

We subtract the gross amount paid to you as an Accelerated Life Benefit from the amount of your group term life insurance under this plan. The remaining amount of your group term life insurance is permanently reduced by the gross amount paid to you.

By "group term life insurance" we mean any Employee Optional Group Term Life Insurance for which you are insured under this plan. "Group term life insurance" does not mean Accidental Death and Dismemberment Benefits, any insurance provided under this plan for covered persons other than you or any scheduled increase in the amount of any Employee Group Term Life Insurance that is due within the 6 month period after the date you apply for the Accelerated Life Benefit.

By "gross amount" we mean the amount of an Accelerated Life Benefit elected by you, before the discount and the processing fee are subtracted.

For the purposes of this provision, "terminal condition" means a medical condition that is expected to result in your death within 6 months.

You may use the Accelerated Life Benefit in any way you choose. But you may receive only one Accelerated Life Benefit during your lifetime. If you live longer than 6 months, or if you recover from the condition, the benefit does not have to be repaid. But the amount of this benefit is not restored to your remaining group term life insurance. And you may not receive another Accelerated Life Benefit if you have a relapse or develop another terminal condition.

Maximum Benefit Amount

The amount of the Accelerated Life Benefit for which you may apply is based on the amount of group term life insurance for which you are insured on the day before you apply for the benefit. The minimum benefit amount is the lesser of: (a) $10,000.00; or (b) 50% of the inforce amount. The maximum benefit amount is the lesser of: (a) $250,000.00; or (b) 50% of the inforce amount.

Discount

The amount for which you apply is discounted to the present value in 6 months from the date the benefit is paid, based on the maximum adjustable policy loan interest rate permitted in the state in which your employer is located.

A detailed statement of the method of computing the amount of the Accelerated Life Benefit is filed with each state insurance department. This statement is available from The Guardian upon request.

Processing Fee

A fee of up to $150.00 may also be required for the administrative cost of evaluating and processing your Accelerated Life Benefit. This fee is deducted from the amount of the Accelerated Life Benefit paid to you.

Payment of An Accelerated Life Benefit

If we approve your application for an Accelerated Life Benefit, we pay the amount you have elected, less the discount and the processing fee. We pay the benefit to you in one lump sum. And what we pay is subject to all of the other terms of this plan.

How And When To Apply

To receive the Accelerated Life Benefit, you must send us written proof from a licensed doctor who is operating within the scope of his or her license that your medical condition is expected to result in your death within 6 months of the date of the written medical proof. We must approve such proof in writing before the Accelerated Life Benefit will be paid.

We can have you examined by a doctor of our choice to verify the terminal condition. We'll pay the cost of such examination. We will not pay the Accelerated Life Benefit if our doctor does not verify the terminal condition.

If we approve you to receive an Accelerated Life Benefit, we give you a statement which shows: (a) the amount of the maximum Accelerated Life Benefit for which you are eligible; and (b) the amount by which your group term life insurance will be reduced if you elect to receive the maximum Accelerated Life Benefit; and (c) the amount of the processing fee.

Even if you are receiving an Extended Life Benefit under this plan, you can still apply for an Accelerated Life Benefit. However, once you convert your group term life insurance, the terms of the converted life policy will apply. Any amount to which you could otherwise convert is permanently reduced by the gross amount of the Accelerated Life Benefit paid to you.

Please read "Your Remaining Group Term Life Insurance" provision for restrictions that may apply.

If You Have Assigned Your Group Term Life Insurance

If you have already assigned your group term life insurance, according to the terms of this plan, you can't apply for an Accelerated Life Benefit.

CGP-3-R-EALB-95 B275.0027

If You Are Incompetent

If you are determined to be legally incompetent, the person the court appoints to handle your legal affairs may apply for the Accelerated Life Benefit for you.

Your Remaining Group Term Life Insurance

The remaining amount of group term life insurance for which you are covered after receiving an Accelerated Life Benefit payment is subject to any increases or cutbacks that would otherwise apply to your insurance. Applicable cutbacks are applied to the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

The premium cost of your remaining coverage is based on the amount of group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

You may be required to provide proof of insurability for increased amounts. If you are, we must approve that proof in writing before you are covered for the new amount.

The total amount of group term life insurance your beneficiary would Otherwise receive upon your death is reduced by the gross amount of the Accelerated Life Benefit paid to you.

If you die after electing the Accelerated Life Benefit, but before we send the benefit to you, your beneficiary will receive the amount of the group term life insurance for which you are insured on the day before you apply for the Accelerated Life Benefit.

Restrictions

We will not pay an Accelerated Life Benefit to you if you:

- are required by law to use the payment to meet the claims of creditors, whether or not you are in bankruptcy; or
- are required by court order to pay all or part of the benefit to another person; or
- are required by a government agency to use the payment to apply for, to receive or to maintain a governmental benefit or entitlement; or
- lose your coverage under the group plan for any reason after you elect the Accelerated Life Benefit but before we pay such benefit to you.

CGP-3-EALB-17-IL B270.0322

Your Extended Life Benefit With Waiver Of Premium

Important Notice

This section applies to your basic life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent basic life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled

You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your basic life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) 09 continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

CGP-3-R-LW-TD-99-1 B275.0513

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death

We'll pay as soon as we receive

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2 B275.0059

LifeAssist

If you are eligible for this plan's Basic Life Extended Life Benefit you may also be eligible for the LifeAssist benefit.

When And How The LifeAssist Benefit Begins

You become eligible for LifeAssist benefits when all of the following conditions are met:

(a) you are eligible for this plan's Basic Life Extended Life Benefit; and

(b) you are functionally disabled, as defined below.

Functional Disability or Functionally Disabled means, due to sickness or injury, you are:

(a) not able to perform 2 or more activities of daily living on a routine basis, without help; or

(b) cognitively impaired and need verbal cueing to protect yourself or others; and

you are:

(c) receiving regular doctor's care appropriate to the cause of disability; and

(d) not working for wage or profit.

Activities of Daily Living means:

(1) Bathing: the ability to wash in a tub or shower; or by taking a sponge bath; and to towel dry, with or without adaptive equipment or adaptive devices.

(2) Dressing: the ability to put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and also to fasten or unfasten them.

(3) Toileting: the ability to get to and from and on and off the toilet; to maintain personal hygiene; and to care for clothes.

(4) Transferring: the ability to move in and out of a chair or bed with or without equipment such as: canes; walkers; crutches; grab bars; or any other support devices.

(5) Continence: the ability to control bowel and bladder function; or, in the event of incontinence, the ability to maintain personal hygiene.

(6) Eating: the ability to get food into the body by any means once it has been prepared and made available.

Cognitively impaired means a decline or loss in intellectual aptitude. Such loss may result from: (a) injury; (b) sickness; (c) Alzheimer's disease; or (d) similar forms of senility or irreversible dementia. It must be supported by clinical proof and standardized tests that precisely measure decline in the areas of: (i) short term memory; (ii) orientation to time, place and person; (iii) deductive or abstract reasoning; and (iv) judgement as it relates to awareness of safety.

Payment Of Benefits

We pay this benefit monthly, in arrears. We pay benefits to you if you are legally competent. If you are not, we pay benefits to the legal representative of your estate.

What We Pay

Subject to all the terms of this plan, the monthly LifeAssist benefit is equal to 1% of your Basic Life Extended Life Benefit, to a monthly maximum of $2,000.00.

Payments are made based on a 30 day month. You may be eligible for the LifeAssist benefit for only part of a month. In such case, we compute the benefit payable as 1/30th of the monthly benefit times the number of days you are eligible for this benefit.

While you are approved for the Basic Life Extended Life Benefit, if your insurance coverage is reduced under the extension, the amount of the LifeAssist benefit is reduced accordingly.

Continued Eligibility For The LifeAssist Benefit

We may require periodic written proof that you remain functionally disabled. This written proof of your continued disability and regular doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary.

When The LifeAssist Benefit Ends

We stop paying this benefit on the earliest of the following dates:

(a) the date you are no longer functionally disabled;

(b) the date you are no longer eligible for this Basic Life plan's Extended Life Benefit;

(c) the date we ask you to take part in a medical assessment and you refuse;

(d) the date you do not give us proof of disability that we require;

(e) the date you are no longer receiving regular doctor's care appropriate to the disability; and

(f) the date the lifetime maximum LifeAssist benefit is reached.

The lifetime maximum LifeAssist benefit payments to be made to you by this plan are 100 months of benefit payments.

CGP-3-R-LSUPP-99 B275.0350

Your Extended Life Benefit With Waiver Of Premium

Important Notice

This section applies to your optional life benefit. But, it does not apply to your accidental death and dismemberment benefits; nor to any of your dependent's insurance under this group plan. In order to continue dependent optional life insurance, you must convert your dependent coverage to an individual permanent policy.

If You Are Disabled

You are disabled if you meet the definition of total disability, as stated below. If you meet the requirements in the "How and When to Apply" provision, we'll extend your optional life insurance under this section without payment of premiums from you or the employer.

Total Disability or Totally Disabled means, due to sickness or injury, you are:

(a) not able to perform any work for wages or profit; and

(b) you are receiving regular doctor's care appropriate to the cause of disability.

How And When To Apply

To apply for this extension, you must submit satisfactory written medical proof of your total disability within one year of the onset of that disability. Any claim filed after one year from the onset of total disability will be denied, unless we receive written proof that: (a) you lacked the legal capacity to file the claim; or (b) it was not reasonably possible for you to file the claim.

Also, in order to be eligible for this extension, you must:

(a) become totally disabled before you reach age 60 and while insured by the group plan; and

(b) remain totally disabled for 09 continuous months.

You are encouraged to apply for this benefit immediately upon the onset of disability.

Continued Eligibility For Extended Life Benefit

We may require periodic written proof that you remain totally disabled to maintain this extension. This written proof of your continued disability and doctor's care must be provided to us within 30 days of the date we make each such request.

We can require that you take part in a medical assessment, with a medical professional of our choice, as often as we feel is reasonably necessary during the first two years we've extended your life benefits. But after two years, we can't have you examined more than once a year.

Until You've Been Approved For This Extended Life Benefit

Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

(a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or

(b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

However, if this group plan terminates, and you are totally disabled and eligible, but not yet approved, for this extended benefit, you must convert to an individual permanent or term policy, and remain insured under such policy until you are approved by us for the extended benefit.

Converting does not stop you from claiming your rights under this section. But if you convert and we later approve you for this extended benefit, we'll cancel the converted policy as of our approval date. Once you are approved for this extended benefit, your group term life coverage will be reinstated at no further cost to you or the employer.

When This Extension Begins

Once approved by us, your extended benefit will be effective on the later of:

(a) 09 continuous months from the date active full-time service ends due to total disability; or

(b) the date we approve you for this benefit.

Your Extended Life Benefit With Waiver Of Premium (Cont.)

When This Extension Ends

Your extension will end on the earliest of:

(a) the date you are no longer disabled;

(b) the date we ask you to be examined by our doctor, and you refuse;

(c) the date you do not give us the proof of disability we require;

(d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or

(e) the day before the date you reach age 65.

If the extension ends, and you are not insured by the group plan again as an active full-time employee, you can convert as if your employment just ended. Read the section labeled "Converting This Group Term Life Insurance".

If You Die While Covered By This Extension

If you die while covered by this extension we'll pay your beneficiary the amount for which you were covered as of your last day of active full-time work, subject to all reductions which would have applied had you stayed an active employee.

Proof Of Death

We'll pay as soon as we receive

(a) written proof of your death, that is acceptable to us; and

(b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2 B275.0059

Your Basic Accidental Death And Dismemberment Benefits

The Benefit

We'll pay the benefits described below if you suffer an irreversible covered loss due to an accident that occurs while you are insured. The loss must be a direct result of the accident, independent of all other causes. And, it must occur within 365 days of the date of the accident.

Covered Losses

Benefits will be paid only for losses identified in the following table. The Insurance Amount is shown in the Schedule.

ACCIDENTAL DEATH AND DISMEMBERMENT

Covered Loss	Benefit
Loss of Life	100% of Insurance Amount
Loss of a hand	50% of Insurance Amount
Loss of a foot	50% of Insurance Amount
Loss of sight in one eye	50% of Insurance Amount
Loss of thumb and index finger of same hand	25% of Insurance Amount

For covered multiple losses due to the same accident, we will pay 100% of the Insurance Amount. We won't pay more than 100% of the Insurance Amount for all losses due to the same accident.

Loss of:

(a) a hand or foot means it is completely cut off at or above the wrist or ankle.

(b) sight means the total and permanent loss of sight.

Payment Of Benefits

For covered loss of life, we pay the beneficiary of your basic group term life insurance.

For all other covered losses, we pay you, if you are living. If not, we pay the beneficiary of your basic group term life insurance.

We pay all benefits in a lump sum, as soon as we receive proof of loss which is acceptable to us. This should be sent to us as soon as possible.

CGP-3-R-ADCL1-00 B310.1138

Exclusions

We won't pay for any loss caused directly or indirectly:

- by willful self-injury, suicide, or attempted suicide;
- by sickness, disease, mental infirmity, medical or surgical treatment;
- by your taking part in a riot or other civil disorder; or in the commission of or attempt to commit a felony;
- by travel on any type of aircraft if you are an instructor or crew member; or have any duties at all on that aircraft;
- by declared or undeclared war or act of war or armed aggression;
- while you are a member of any armed force;
- while you are a driver in a motor vehicle accident, if you do not hold a current and valid driver's license;
- by your legal intoxication; this includes, but is not limited to, your operation of a motor vehicle; or
- by your voluntary use of a controlled substance, unless: (1) it was prescribed for you by a doctor; and (2) it was used as prescribed. A controlled substance is anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.

CGP-3-R-ADCL2-00 B310.1049

CERTIFICATE AMENDMENT

(To be attached to certificates issued to you)

The certificate is amended as follows:

This rider amends this plan's Life Insurance certificate as follows:

1. The Examination Period provision as shown below is hereby added to your certificate:

Examination Period

A person age 65 or older insured under the policy has the right to return the policy or certificate, by mail or other delivery method, within 30 days after its receipt, and to have the full premium and any policy or membership fee paid refunded.

2. The Continuation of Coverage During a Labor Dispute provision as shown below is hereby added to your certificate:

Continuation Of Coverage During A Labor Dispute

Important Notice: This section does not apply to coverage which provide benefits for loss of income due to disability. All other coverages under the group plan are affected by this section, and are hereafter referred to as "group coverage."

If A Work Stoppage Occurs: A labor dispute may result in a work stoppage which causes an employee's group coverage to end. If this happens, an employee has the right to continue his health coverage for himself and his dependents during the work stoppage, for up to six months.

How To Continue Group Coverage: To continue his group coverage an employee must make timely payment of the total premium, including any portion of the premium the employer was paying before work stopped, to the Policyholder. If an employee fails to pay a premium on time, he waives his right to continue under this section.

The Responsibilities of the Policyholder: For an employee's group coverage to continue, the Policyholder must do the following:

(a) collect the premium payments made by an employee; and

(b) make timely payment of the collected premiums to us.

If Policyholder, after timely receipt of the employee's premium, fails to pay us on behalf of such employee, thereby causing the employee's group coverage to end, then Policyholder will be liable for the employee's benefits, to the same extent as, and in place of, us.

The Premium: The premium to be paid by an employee for continued group coverage will be at the rate that applies to the class of employees to which he belonged on the day work stopped. But, we have the right to increase this rate by up to 20%, or any higher amount approved by the Insurance Commissioner, to allow for increased costs and risks caused by this continued coverage. We may do this at any time during the continuation. Nothing in this section alters our right to change premium rates according to the "Premiums" section of the group plan.

When This Continuation Starts: Group coverage continued under this section starts on the day work stopped. But, if a premium that was due before the work stoppage began is unpaid at the time work stopped, then payment of such premium before the next premium due date will be required for this continuation to take effect.

When This Continuation Ends: An employee's continued group coverage ends on the first of the following:

(a) the end of the six month continuation period;

(b) the day on which the number of employees covered under this section is less than 75% of those insured under the group plan on the day work stopped;

(c) the day the work stoppage ends;

(d) when the employee enters full-time employment with another employer;

(e) at the end of the period for which the last premium payment is made, if the employee stops paying premium;

(f) the date the employee stops being eligible as defined in this plan, for reasons other than not meeting "actively at work" or "full-time" requirements; and

(g) with respect to a dependent, the date such dependent stops being an eligible dependent as defined in the group plan.

3. The Incontestability provision is hereby replaced, as follows:

Incontestability The validity of the policy shall not be contested, except for non-payment of premiums, after it has been in force for two years from its date of issue. No statements made by any person insured under the policy relating to his or her insurability shall be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force prior to the contest for a period of two years during such person's lifetime nor unless it is contained in a written statement signed by such person.

If a photographic identification is presented during the application or enrollment process, and if an imposter is substituted for an insured person in any part of the application or enrollment process, with or without the knowledge of such person, then no contract between Guardian and such person is formed, and any purported insurance contract is void from its inception.

Application or enrollment process means any or all of the steps required of an insured person in applying for a certificate under a group policy of life insurance, including, but not limited to, executing any part of the application or enrollment form, submitting to medical or physical examination or testing, or providing a sample or specimen of blood, urine, or other bodily substance

Imposter means a person other than the insured person who participates in any manner in the application or enrollment process for a certificate under a group life insurance policy and represents himself or herself to be the insured person or represents that a sample or specimen of blood, urine, or other bodily substance is that of the insured person.

A Policyholder insurance under this policy shall be incontestable after two years from the Policyholder policy date of coverage under this policy, except for nonpayment of premiums.

If this policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or insured person's signed application for up to two years from this policy's policy date.

4. The Contract provision is hereby replaced, as follows:

The Contract The entire contract between the Guardian and the policyholder consists of this policy, the policyholder's application, a copy of which is attached hereto or endorsed hereon, and the individual applications, if any, of the employees.

We can amend this policy at any time, without the consent of the insured employees or any other person having a beneficial interest therein, as follows:

We can amend this policy: (a) upon written request made by the policyholder and agreed to by the Guardian; (b) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (c) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

If we amend the policy, except upon request made by the policyholder, we must give the policyholder written notice of such amendment.

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

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

All personal pronouns in the masculine gender used in this policy, will be deemed to include the feminine also, unless the context clearly indicates the contrary.

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

The Guardian Life Insurance Company of America

Michael Prestileo, Senior Vice President

B531.0684

CGP-3-A-REV-CA-18

GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90 B900.0118

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

CGP-3-GLOSS-90 B900.0003

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

CGP-3-GLOSS-90 B750.0015

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

CGP-3-GLOSS-90 B750.0006

Employer means INSHORE .

CGP-3-GLOSS-90 B900.0051

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

CGP-3-GLOSS-90 B900.0004

Full-time means the *employee* regularly works at least the number of hours in the normal work week set by the *employer* (but not less than 30 hours per week), at his *employer's* place of business.

CGP-3-GLOSS-90 B750.0229

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

CGP-3-GLOSS-90 B900.0006

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

CGP-3-GLOSS-90 B900.0008

Plan means the *Guardian* group *plan* purchased by your *employer,* except in the provision entitled "Coordination of Benefits" where "plan" has a special meaning. See that provision for details.

CGP-3-GLOSS-90 B900.0039

Proof or Proof of Insurability means an application for insurance showing that a person is insurable.

CGP-3-GLOSS-90 B900.0010

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

STATEMENT OF ERISA RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order

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

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

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

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

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

B800.0094

The Guardian's Responsibilities

B800.0048

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

B800.0049

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

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

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

Alternative Dispute Options

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

B800.0076

Termination of This Group Plan

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

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

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

B800.0007

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Life Insurance Claims Procedure

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

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

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

Definitions

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

Timing for Initial Benefit Determination of Life Insurance Claims

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

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

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

Adverse Benefit Determination of Life Insurance Claims

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

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

B752.0173

Appeals of Adverse Determinations of Life Insurance Claims

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

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

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

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

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

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

Waiver of Premium

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

Timing For Initial Benefit Determination for Waiver of Premium

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

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

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

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

Adverse Benefit Determination

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

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

B752.0067

Appeals of Adverse Determinations for Waiver of Premium

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;
- Provide a statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, provide an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you, and vocational professionals who evaluated you;
- If applicable, provide an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, provide an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- Provide a statement describing the claimant s right to bring a civil suit under Section 502(a) of the Employee Retirement Income Security Act of 1974 which shall also describe any applicable contractual limitations period that applies the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim, and;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Alternative Dispute Options

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

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

B752.0068

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Prudent Actions by Plan Fiduciaries

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

Enforcement of Your Rights

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

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

Assistance with Questions

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

Accidental Death and Dismemberment Insurance Claims Procedure

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

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

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

Definitions

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

Timing for Initial Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

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

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

Adverse Benefit Determination of Accidental Death and Dismemberment Insurance Claims

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

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

B752.0188

Appeals of Adverse Determinations of Accidental Death and Dismemberment Insurance Claims

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

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

In reviewing an appeal, Guardian will:

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

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

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

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

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonably access to, and copies of all documents, records, and other information relevant to the claimant's claim for benefits;

- In the event the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, provide either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Waiver of Premium

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

Timing For Initial Benefit Determination for Waiver of Premium

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

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

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

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

Adverse Benefit Determination

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

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

- A statement disclosing any internal rule, guideline, protocol or similar criterion relied on in making the adverse benefit determination (or a statement that such information will be provided free of charge upon request); or a statement that no internal rule, guideline, protocol or similar criterion was relied upon in making the adverse benefit determination;
- If applicable, an explanation of the basis of disagreement with or not following the views presented by you, of health care professionals who treated you and vocational professionals who evaluated you;
- If applicable, an explanation of the basis for disagreeing with or not following the views of any medical or vocational expert whose advice was obtained on our behalf in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the determination;
- If applicable, an explanation of the basis for disagreeing with or not following a disability determination made by the Social Security Administration that you present to us;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination; and
- In the case of adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request.

B752.0103

Appeals of Adverse Determinations for Waiver of Premium

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

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- In deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;

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

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

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

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

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

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

Alternative Dispute Options

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

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

B752.0104

COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017
1-800-273-3330

This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage.

The Group Dental Coverage described in this Evidence of Coverage is attached to the group policy "Policy" effective October 1, 2010. This Evidence of Coverage replaces any Evidence of Coverage previously issued under this Policy or under any other policy providing similar or identical benefits issued to the Policyholder by Us.

Managed Dental Care (MDC) of California is a California corporation, licensed as a Knox-Keene Heath Care Service Plan under applicable California law, whose primary purpose is to operate a dental care service plan.

MANAGED DENTAL CARE PLAN

GROUP CONTRACT FOR PREPAID DENTAL SERVICES

PLEASE READ THIS ENTIRE EVIDENCE OF COVERAGE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHAT IT COVERS, LIMITS, AND EXCLUDES.

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

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

Policyholder: INSHORE
Group Policy Number: 00460357
Effective Date: October 1, 2010

GC-DHMO-23-CA

Managed Dental Care of California

Jill M. Purcell, President

Larry Weiss, Assistant Vice President
and Controller

B425.1256

GC-DHMO-23-CA

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GENERAL PROVISIONS

Applicable Benefits

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

- They were previously selected in an acceptable manner and mode, such as an enrollment form or other required form; and
- We have received any required premium.

B425.0637

Public Policy Committee

MDC maintains a Public Policy Committee composed of at least three Members, one Contracted Dentist and one member of MDC's Board of Directors. Members may call MDC for more information about the Committee. MDC communicates material changes affecting public policy to Members in periodic newsletters.

B425.0638

Confidentiality

A STATEMENT DESCRIBING OUR POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

You may contact Our customer services department at the address below to request a copy of the Policy's confidentiality statement. The confidentiality statement describes how MDC maintains the confidentiality of dental information obtained by and in the possession of MDC.

We will direct all confidential communications regarding your receipt of Sensitive Services directly to you. Confidential communications include bills, explanation of benefits, claims, information regarding a session, or other communications containing medical information or provider name and address related to dental services, including information relating to Sensitive Services, that you have received. Unless otherwise directed by you, we will communicate confidential information to you by contacting you at the mailing address, email address, or telephone number on file. If you would like to receive confidential communications in a specific form and format or at an alternative location, please submit a request as follows:

Customer Services Department
P.O. Box 25256
Lehigh Valley, PA 18002-5256
1-800-273-3330

We will accommodate and implement requests for confidential communications in the form and format requested by you, if confidential communications are readily producible in the requested form and format or at alternative locations. We will acknowledge your request for a confidential communication and advise you of the status. We will provide you with confidential communications within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt of a request by mail. Your request for a confidential communication will be valid until you revoke your request, or you submit a new request for a confidential communication.

We will not disclose medical information related to Sensitive Services you receive to your policyholder, the primary subscriber, or any other member, absent your express written authorization to do so. You are not required to obtain authorization from your policyholder, the primary subscriber, or any other member in order for you to receive Sensitive Services or to submit a claim for Sensitive Services.

B425.1254

Limitation of Authority

Only Our President, a Vice President or a Secretary has the authority to act for Us in a written and signed statement to:

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

Agents and brokers do not have the authority to change the contract or Policy or waive any of its provisions.

B425.0640

Incontestability

All statements made on Your enrollment form shall be considered representations and not warranties. The statements are considered to be truthful and are made to the best of Your knowledge and belief. No statement contained in Your enrollment form will void Your coverage or reduce Your benefits after Your coverage has been in force for two years. Within the first two years of issuance of coverage under this Policy, We may rescind Your coverage based on any fraudulent statement or intentional misrepresentation of material fact made on Your signed enrollment application.

The statements and information contained in the Your enrollment form are represented by You to be true and correct and incorporated into the Policy. You also recognize that MDC has issued the Policy in reliance on those statements and information. The Policy replaces and cancels all other contracts, if any, issued to You by Us.

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

B425.1024

Language Assistance

As an MDC Member, You have a right to free language assistance services, including interpretation and translation services. MDC collects and maintains Your language preferences, race, and ethnicity so that We can communicate more effectively with Our Members. If You require spoken or written language assistance or would like to inform MDC of Your preferred language, please contact Us at 1-800-273-3330. TDD/TTY for the hearing impaired is available through 1-800-947-6644.

B425.1026

CONDITIONS OF ELIGIBILITY FOR GROUP DENTAL COVERAGE

B425.0011

Enrollment Procedures

You may enroll for dental coverage by:

- Completing and signing the appropriate enrollment form and any additional material required by Your Policyholder.
- Returning the enrollment material to your Policyholder. Your Policyholder will forward these materials to Us.

The enrollment materials require You to select a Primary Care Dentist ("PCD") for each Member. After Your enrollment material has been received by Us, We will determine if a Member's selected PCD is available under Your Policy. If the PCD is available under the Policy, the selected Dentist will be assigned to the Member as his or her PCD. If a Member's selection is not available, an alternate Dentist will be assigned as the PCD. A Member need only contact his or her assigned PCD's office to obtain services.

We will issue You and Your dependents, either directly or through Your Policyholder's representative, an ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

B425.1038

Open Enrollment Period

If You do not enroll Yourself or Your eligible dependents for dental coverage under this Policy within 30 days of: a) the date of becoming eligible or b) the date of a Qualifying Event, You must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period which occurs once every 12 months after this Policy's Effective Date, or at time intervals mutually agreed upon by Your Policyholder and Us.

Enrollment is for a minimum of 12 consecutive months while You are eligible. Voluntary termination from this Policy will only be permitted during the open enrollment period.

If after initial enrollment You, or one of Your dependents disenroll from the Policy before the open enrollment period, the Member may not re-enroll until the next open enrollment period which occurs after the Member has been without coverage for one full year.

B425.1027

Employee Eligibility

You are eligible for dental coverage if You are:

- In an eligible class of Employees;

- An active Full-Time Employee;
- A dues paying Member in good standing; and
- Working at least the minimum required number of hours in Your eligible class at:
    - The Employer's place of business;
    - Some place where the Employer's business requires You to travel; or
    - Any other place You and the Employer have agreed upon for the performance of the major duties of Your job.

You are **not** eligible for dental coverage if You are:

- A temporary or seasonal Employee; or
- The Employee for whom, pursuant to a collective bargaining agreement, the Employer makes any payments to any kind of health and welfare benefit plan other than under this Evidence of Coverage.

B425.0648

Dependent Eligibility

Your eligible dependents are Your:

- Spouse; and
- Dependent child, including:
    - A newborn child, natural child, stepchild or a child placed with You for adoption or foster care who is under age 26; and
    - A child who is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition; and is chiefly dependent upon the Employee for support and maintenance, may remain eligible for dependent benefits past the age limit, subject to the following:
        - We will send notice to You at least 90 days prior to the limiting age and You must send Us written proof that the child is dependent upon You for support and maintenance as is incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition. You have 60 days from the date the child reaches the age limit to do this. We will continue coverage until a determination about the childs eligibility is made. We can ask for periodic proof that the childs condition continues, but We cannot ask for this proof more than once a year after the two-year period following the childs attainment of the limiting age.

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

B425.1047

When Coverage Starts

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

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

If you do not enroll by Your Effective Date, Your coverage will begin on:

- The first day of the month following the date enrollment materials are received by Us; or
- The first day of the month after the end of any waiting period Your Policyholder may require; or
- The date you are eligible for the Policy based on the Policyholder's eligibility rules as approved by Us.

B425.0392

Exception to When Coverage Starts

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

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

And if:

- You were fully capable of performing Active Work for the Employer for the minimum number of hours of the Employee in Your eligible class at 12:01 AM Standard Time for Your place of residence on the scheduled Eligibility Date; and

- You were Actively at Work and working the minimum number of hours of the Employee in Your eligible class on Your last regularly scheduled work day;

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

B425.0674

Termination of Coverage

In the event of cancellation by either Us (except in the case of fraud or deception in the use of services or facilities of MDC or knowingly permitting such fraud or deception by another) or You, We shall within 30 days return to You any pro rata portion of fees paid by You which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due.

Termination by You
You may cancel your coverage at any time during the grace period outlined below or by giving Us 31 days advance written notice. This notice must be sent to Our office. The Policyholder will owe Us all unpaid premiums for the period that coverage is in force.

Termination by MDC
We shall have the right to cancel Your coverage upon providing written notice to the Policyholder, who is required to promptly send such notice to You, in the following circumstances:

- Termination by MDC for Non-payment of Premium. We may cancel or decline to renew Your coverage for cause if the Policyholder fails to pay all premiums in accordance with the following terms and conditions:

- A grace period of 30 days, starting after the last date of paid coverage, will be allowed for outstanding premium payments. You will receive a written notice stating the start and end dates of the grace period from the Policyholder.
- If the Policyholder, or another party acting on the Policyholders behalf, makes the necessary premium payment and that payment is received on or before the last day of the grace period, We shall ensure that coverage is not cancelled or not renewed on account of non-payment of such premiums.
- If any premium with respect to the Members covered by the Policy is not paid before the end of the grace period, coverage ends with respect to all Members covered by the Policy immediately following the end of the grace period. You will receive a written notice of end of coverage no later than five (5) business days following the last day of paid coverage from the Policyholder.
- If the Policyholder give Us advance written notice of an earlier termination date during the grace period, Your coverage will end as of such earlier date.
- If Your coverage ends during or at the end of the grace period, the Policyholder will still owe Us premium for all the time the Policy was in force during the grace period.

- Termination by MDC for Intentional Misrepresentation of Material Fact by You. We may cancel or decline to renew Your coverage if We demonstrate an intentional misrepresentation of a material fact by You or the Policyholder in obtaining Your coverage. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC for Violation of Material Provision Relating to Employer Contributions or Group Participation Rates. We may cancel or decline to renew Your coverage if the Policyholder violates a material provision of the Policy relating to employer contributions or group participation rates. You will receive 30 days' advance written notice of cancellation from the Policyholder.

- Termination by MDC Due to Cessation of Services in the State or Withdrawal of Policy from the Market. Subject to providing 180 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the cancellation or nonrenewal is due to MDC ceasing to provide or arrange for the provision of health benefits for new plan contracts in the individual or group market in this State pursuant to Health and Safety Code section 1365(a)(5). Subject to providing 90 days' advance written notice to the Director of the Department of Managed Health Care and You via the Policyholder, We may discontinue or terminate Your coverage if the MDC withdraws the health benefit plan from the market pursuant to Health and Safety Code section 1365(a)(6).

If You believe that Your coverage has been or will be improperly canceled, rescinded, or not renewed, You may file request a review by the Department of Managed Health Care, within 180 days of receipt of the notice of cancellation, pursuant to Section 1368 of the Health and Safety Code. Such request for review may be submitted directly to the Department of Managed Health Care by mail to the attention of the Help Center, Department of Managed Health Care, 980 Ninth Street, Suite 500, Sacramento, CA 95814-2725; by phone at 1-888-466-2219/TDD 1-877-688-9891; by fax at 1-916-255- 5241; or online at www.healthhelp.ca.gov. Such review shall be in accordance with Sections 1368 and 1365(b) of the Health and Safety Code.

B425.1029

When Your Dependent Coverage Ends

Your dependent Coverage will end on the first of the following events:

- When Your Coverage ends.
- When You stop being an eligible Employee under this Evidence of Coverage.
- The date the group Evidence of Coverage ends, or dependent Coverage is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for Your dependent.
- On the last day of the month in which Your child attains the age limit, except as described in the Dependent Eligibility section.
- For Your Spouse, on the last day of the month in which Your marriage ends in legal divorce or annulment.

B425.0692

CONTINUATION OF COVERAGE

You may have the right to continue certain group benefits for a limited time after Your coverage would otherwise end. Read this Evidence of coverage carefully for details and discuss with Your Employer or administrator.

B425.0696

Continuation Rights

You may be eligible to continue Your group dental coverage under more than one Continuation Rights section at the same time. If You choose to continue Your group dental coverage under more than one section, the continuations: (1) start at the same time; (2) run concurrently; and (3) end independently, on their own terms.

If continuing coverage under more than one continuation section: (1) You will not be entitled to duplicate benefits; and (2) You will not be subject to the premium requirements of more than one section at the same time.

B425.0071

Uniformed Services Continuation Rights

USERRA (Uniformed Services Employment and Reemployment Rights Act) is a federal law that provides reemployment rights for veterans and members of the National Guard and Reserve following military service. It also prohibits employer discrimination against any person on the basis of that person's past military service, current military obligations or intent to join one of the uniformed services.

If Your group dental coverage under this Policy would otherwise end because You enter into active military service, You may elect to continue such coverage for Yourself and Your eligible dependents in accordance with the provisions of USERRA.

You may contact Your Employer for additional information.

B425.0078

Cal-COBRA Continuation Rights

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

This section applies to the dental benefits of this Policy. In this section, these benefits are referred to as "group dental benefits."

Under this section, a "qualified beneficiary" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for dental benefits under this Policy as: (a) an active, covered Employee; (b) the spouse of an active, covered Subscriber; or (c) the dependent Child of an active covered Employee. A child born to, or adopted by, the covered Employee during a continuation period is also a qualified beneficiary if the child is enrolled in the Policy as a dependent within 30 days of the child's birth or placement for adoption. Any other person who becomes covered under this Policy during a continuation period provided by this section is not a qualified beneficiary.

A qualified beneficiary will be eligible for continuation coverage without demonstrating evidence of insurability upon certain "qualifying events." "Qualifying events" are defined as: (a) the death of the covered Employee; (b) the termination or reduction of work hours of the covered Employees employment, if he or she was not terminated for gross misconduct; (c) the divorce or legal separation of the covered Employee from the covered Employees spouse; (d) the loss of dependent status by a dependent enrolled in the group Policy; and (e) the covered Employees eligibility for coverage under Medicare.

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

If Your Group Health Benefits End: If Your group dental benefits end due to Your termination of employment or reduction of work hours, You may elect to continue such benefits for up to 18 months, if You were not terminated due to gross misconduct. The continuation: (a) may cover You or any other qualified beneficiary; and (b) is subject to "When Continuation Ends."

Extra Continuation for Disabled Qualified Beneficiaries: If a qualified beneficiary is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to the Employees termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified beneficiary must give Your Employer written proof of Social Security's determination of his or her disability before the earlier of: (a) the end of the 18 month continuation period; or (b) 60 days after the date the qualified beneficiary is determined to be disabled. If, during this extra 11 month continuation period, the qualified beneficiary is determined to be no longer disabled under the Social Security Act, he or she must notify You within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

An additional 50% of the total premium charge also may be required from the qualified beneficiary by the insurer during this extra 11 month continuation period.

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

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

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

Concurrent Continuations: If a dependent elects to continue his or her group dental benefits due to Your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month continuation period up to 36 months, if during the 18 month continuation period, either: (i) the dependent becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (ii) You become entitled to Medicare.

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

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

B425.0699

The Qualified Beneficiary's Responsibilities: A person eligible for continuation under this section must notify Your Employer, in writing, of: (a) Your legal divorce or legal separation from Your spouse; or (b) the loss of dependent eligibility, as defined in this Policy, of a dependent.

Such notice must be given to Your Employer within 60 days of either of these events. Employee must request the continuation in writing and deliver the written request, by first-class mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the health care service plan, or to the Employer if the Policy has contracted with the Employer for administrative service, within the 60-day period following the later of (1) the date that the Employees coverage under the group benefit plan terminated or will terminate by reason of a qualifying event, or (2) the date the Employee was sent notice of that ability to continue coverage under the group benefit plan. A qualified beneficiary electing continuation shall pay to the Policy, in accordance with the terms and conditions of the Policy Contract, which shall set forth in the notice to the qualified beneficiary, the amount of the required premium payment.

Your Employer's Responsibilities: Your Employer must notify the qualified beneficiary, in writing, of: (a) his or her right to continue this Policy's group dental benefits; (b) the monthly premium he or she must pay to continue such benefits; and (c) the times and manner in which such monthly payments must be made.

Your Employer must provide the qualified beneficiary with written notice of the necessary benefit information, premium information, enrollment forms and instructions within 14 days of: (a) the date a qualified beneficiary's group dental benefits would otherwise end due to Your death or Your termination of employment or reduction of work hours; or (b) the date a qualified beneficiary notifies Your Employer, in writing, of Your legal divorce or legal separation from Your spouse, or the loss of dependent eligibility of a dependent child.

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

Election of Continuation: To continue his or her group dental benefits, the qualified beneficiary must give Your Employer written notice that he or she elects to continue. This must be done within 60 days of the date a qualified beneficiary receives notice of his or her continuation rights from Your Employer as described above. And the qualified beneficiary must pay his or her first month's premium within 45 days by first-class mail, certified mail, or other reliable means of delivery, including personal delivery, express mail, or private courier company, to the Policy, or to the Employer if the Employer has contracted with the Policy to perform the administrative services. The first premium payment must equal an amount sufficient to pay any required premiums and all premiums due, and failure to submit the correct premium amount within the 45-day period will disqualify the qualified beneficiary from receiving continuation coverage pursuant to this article.

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

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group Policy on a regular basis. It includes any amount that Your Employer would have paid. Except as explained in "Extra Continuation for Disabled Qualified Beneficiary," Your Employer may require an additional charge of 2% of the total premium charge. If the qualified beneficiary fails to give Your Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums: A qualified beneficiary's premium payment is timely if, with respect to the first payment after the qualified beneficiary elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date.

When Continuation Ends: A qualified beneficiary's continued group dental benefits end on the first of the following to occur:

a) with respect to continuation upon Your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date of the qualifying event;

b) with respect to a disabled qualified beneficiary who has elected an additional 11 months of continuation, the earlier of: (1) the end of the 29 month period which starts on the date of the qualifying event; or (2) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled qualified beneficiary is no longer disabled under Title II or Title XVI of the Social Security Act;

c) with respect to continuation upon Your death, Your legal divorce or legal separation, or the end of a dependent's eligibility, the end of the 36 month period which starts on the date of the qualifying event;

d) with respect to a dependent whose continuation is extended due to the Employees entitlement to Medicare, while the dependent is on continuation, the end of the 36 month period which starts on the date of the qualifying event;

e) the date Your Employer ceases to provide any group dental plan to any Employee;

f) the end of the period for which the last premium is made;

g) the date he or she becomes covered under any other group dental plan which does not contain any pre-existing condition exclusion or limitation affecting him or her;

h) the date he or she becomes entitled to Medicare.

B425.0700

Family Medical Leave Of Absence (FMLA)

There are certain leaves of absence that may qualify for continuation of coverage under the Family and Medical Leave Act of 1993 (FMLA), or other similar laws. Please contact Your Employer for information regarding such legally mandated leave of absence laws.

B425.0081

Dependent Survivorship Benefit

If You die while covered, We will continue dependent coverage for those of Your dependents who were covered when You died. We will do this for six months at no cost, provided: 1) this Employer's dental coverage remains in force; 2) the dependents remain eligible dependents; and 3) in the case of a Spouse, the Spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under another continuation provision, if any, this free continuation period will be provided as the first six months of such continuation.

B425.0083

DENTAL BENEFITS

This Policy will cover many of the dental expenses incurred by You and those of Your dependents who are covered under this Policy. We interpret how the Policy is to be administered. What We cover and the terms of coverage are explained below.

B425.0084

How to Contact Us

Our customer service associates can assist You with benefit coverage questions, resolving problems, selecting or changing a Dentist. A customer service associate can be reached toll free Monday through Friday at 1-888-273-3330 from 8:00 am to 8:00 pm, Pacific Standard Time. An automated service is also provided after hours for eligibility verification.

B425.1030

Managed Dental Care

This Policy is designed to provide quality dental care while controlling the cost of such care. To do this, the Policy requires Members to seek dental care from Contracted Dentists that belong to the Network.

The Network is made up of Contracted Dentists in the Policy's approved Service Area. A Contracted Dentist is a Dentist that has a participation agreement in force with Us.

When a Member enrolls in this Policy, he or she will get information about current Contracted General Dentists. Each Member must be assigned to a Primary Care Dentist ("PCD"). The PCD will coordinate all of the Member's dental care covered by this Policy. After enrollment, a Member will receive an ID card. A Member must present this ID card or supply the Group Number and Member ID number when he or she goes to their PCD.

All dental services covered by this Policy must be coordinated by the PCD to whom the Member is assigned. What We cover is based on all the terms of this Policy. Please refer to the Schedule of Benefits for Group Dental Coverage information including Covered Dental Procedures and Patient Charges, Benefit Limitations and Exclusions.

B425.1039

Principal Benefits and Coverages

A complete list of Patient Charges, Limitations and Exclusions are included in the Schedule of Benefits section of this Evidence of Coverage. This is an essential part of this document. Many services are provided at no charge to you, while some procedures have a Patient Charge. Services specifically excluded from this coverage are listed in the section titled Exclusions in the Schedule of Benefits. Please read this section carefully. Dental services performed by a Non-Contracted Dentist are not covered, except under certain emergency situations as explained under the section titled Emergency Dental Services.

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF DENTIST DENTAL CARE MAY BE OBTAINED.

B425.0703

Choice of Dentists

A Member may choose any available Contracted General Dentist as his or her PCD. A request to change a PCD must be made to Us. Any such change will be effective the first day of the month following approval however, We may require up to 30 days to process and approve such request. All fees and Patient Charges due to the Member's current PCD must be paid in full prior to such transfer.

B425.0088

Changes in Dentist Participation

We may have to reassign a Member to a different Contracted Dentist if:

- The Member's Dentist is no longer a Contracted Dentist in the Network; or
- We take an administrative action which impacts the Dentist's participation in the Network.

If this becomes necessary, the Member will have the opportunity to request another Contracted Dentist.

If a Member has a dental service in progress at the time of the reassignment, We will, at Our option and subject to applicable law, either:

- Arrange for completion of the services by the original Dentist; or
- Make reasonable and appropriate arrangements for another Contracted Dentist to complete the service.

B425.0089

Refusal of Recommended Treatment

A Member may decide to refuse a course of treatment recommended by his or her PCD or Contracted Specialist. The Member can request and receive a second opinion by contacting a customer service associate. If the Member still refuses the recommended course of treatment, the PCD or Contracted Specialist may have no further responsibility to provide services for the condition involved and the Member may be required to select another PCD or Contracted Specialist.

B425.0090

Specialty Referrals

A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Contracted Specialist. We will pay for covered services for specialty care, less any applicable Patient Charges, when such specialty services are provided in accordance with the specialty referral policy guidelines described below.

In order for specialty services to be covered by this Policy, the referral policy guidelines stated below must be followed:

- A Member's PCD must coordinate all dental care. Any Member who elects specialty care without prior referral by his or her PCD will be responsible for all charges incurred.
- When the PCD determines that the care of a Contracted Specialist is required, the PCD must complete the specialty referral request form. At this point, the following options are available:

  (a) The PCD may decide to preauthorize the specialty care he or she feels is necessary. The PCD will forward all necessary documentation to Us. We will review the documentation and provide a written response with a benefit determination. The Member will be instructed to contact the Contracted Specialist to schedule an appointment.

  (b) The PCD may determine that the direct referral to the Contracted Specialist fits the referral policy guidelines. If so, the PCD will complete the specialty referral request form and provide this form to the Member and the Contracted Specialist. We will retrospectively review the direct referral upon receipt of the Contracted Specialist's claim, once the Contracted Specialist's procedures or services have been completed.

If the PCD's request for specialty referral is denied (an Adverse Determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. Refer to the Grievance Process section for additional information.

If the service in question is a covered service and no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide additional information.

A specialty referral is not a guarantee of covered services. The Policy's benefits, conditions, limitations and exclusions will determine coverage in all cases. If a referral is made for a service that is not a covered service under the Policy, the Member will be responsible for the entire amount of the specialist's charge for that service.

A Member who receives authorized specialty services must pay all applicable Patient Charges associated with the services provided.

When specialty dental care is referred by the PCD, a Member will be referred to a Contracted Specialist for treatment. The Network includes Contracted Specialists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Policy's approved Service Area. If there is no Contracted Specialist in the Policy's approved Service Area, We will refer the Member to a Non-Contracted specialist Dentist of Our choice.

B425.0091

Facilities

MDC PCD's available under the Policy Contract are listed in the Network General Dentist booklet. MDC's PCD offices are open during normal business hours and some offices are open limited Saturday hours. Please remember, if You cannot keep Your scheduled appointment, You must notify Your PCD at least 24 hours in advance or You will be responsible for the broken appointment fee listed in the Covered Dental Services and Patient Charges section of this booklet. Broken appointment fees will be waived in exigent circumstances (e.g., emergency hospitalization of Member).

You may contact MDC's Member Services Department at 1-800-273-3330 to request the Network General Dentist booklet.

B425.1040

Telehealth

MDC shall provide coverage for health care services appropriately delivered through telehealth on the same basis and to the same extent that the Member has coverage for the same service through in-person diagnosis, consultation, or treatment.

B425.1223

Emergency Dental Services

The MDC Network also provides for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. You should contact Your selected PCD, who will arrange for such care. If You are not able to reach Your PCD in an emergency during normal business hours, You must call MDC's Member Services Department for instructions. If You are not able to reach Your PCD in an emergency after normal business hours, You may seek Emergency Dental Services from any Dentist. MDC will reimburse You for the cost of the Emergency Dental Services less any Patient Charge which may apply. You should present a statement from the treating Dentist. You must file a claim within 180 days of service. This should be submitted to the address listed on page 1.

B425.1224

Out-of-Area Emergency Dental Services

If You are out of the area, and Emergency Dental Services are required, You should seek palliative treatment from a Dentist. You must file a claim within 180 days of service. You must present a detailed statement from the treating Dentist, which lists the services provided. MDC will reimburse you within 30 days for any covered Emergency Dental Services, less applicable Patient Charges, up to $50 per incident. This paperwork should be submitted to the address listed on page 1.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

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

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

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

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

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

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

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

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

B425.1031

Continuity of Care - Terminated Dentist

The Member may request for the continuation of covered services to be rendered by a terminated Contracted Dentist when the Member is undergoing treatment from a terminated Dentist for an acute condition or serious chronic condition, performance of surgery or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days of the contract termination date for current Members or 180 days from the effective date for newly covered Members. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Contracted Dentist's Agreement or 12 months from the effective date of coverage for newly covered Members.

This provision does not apply to Contracted Dentists who voluntarily leave the plan. The Member must make the request in writing and send to:

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. The terminating Dentist must accept the contracted rate for that Member's treatment and agree not to seek payment from the Member for any amounts for which the Member would not be responsible if the Dentist were still in the network. The approval of the request to continue Member's treatment will be at the discretion of the Dental Director. MDC is not required to provide benefits that are not otherwise covered under the terms and conditions of the group contract. In the event the terminating Dentist or Member wishes to appeal an adverse decision, the Peer Review Committee will review the request and make the final determination.

This provision will not apply to any terminated Dentist for reasons relating to a disciplinary cause or reason, as defined in paragraph (6) of subdivision (a) of Section 805 of the Business and Professional Code, or fraud or other criminal activity.

B425.1257

Continuity of Care - Non-Contracted Dentist

The Member, including a newly covered Member, may request for the continuation of covered services to be rendered by the Non-Contracted Dentist when the Member is undergoing treatment from the Non-Contracted Dentist for an acute condition, serious chronic condition, performance of surgery, or other procedure authorized by MDC as part of a documented course of treatment that is to occur within 180 days. This includes completion of covered services for newborn children between birth and age 36 months for 12 months from the termination date of the Non-Contracted Dentist's Agreement or 12 months from the Effective Date of coverage for newly covered Members. The Member must make the request in writing and send to:

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017

Or contact MDC's customer services department at 1-800-273-3330 during normal business hours. MDC may obtain copies of the Member's dental records from the Member's Dentist in order to evaluate the request. The Dental Director (or his/her designee) will determine if the Member is eligible for continuation of care under this Policy and the California Knox-Keene Act.

The Dental Director's decision shall be consistent with professionally recognized standards of practice. The Dental Director shall consider:

1. Whether one of the circumstances described above exists;
2. Whether the requested services are covered by Policy; and
3. The potential clinical effect that a change of Dentist would have on the Member's treatment.

B425.1258

If a Member's coverage ends, We extend dental expense benefits for him or her under this Policy. We extend benefits for covered services other than orthodontic services only if the procedures are started before the Member's coverage ends and are completed within 90 days after the date his or her coverage ends.

- Inlays, onlays, crowns and bridges are started on the date the tooth or teeth are initially prepared.
- Dentures are started on the date the impressions are taken.
- Root canals are started on the date the pulp chamber is opened.

Coverage for orthodontic services ends upon the termination of the Member's coverage under this Policy.

The extension of benefits ends 90 days after the Member's coverage ends or the date he or she becomes covered under another plan which provides coverage for similar dental procedures, whichever occurs first. But, if the plan which succeeds this Policy excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the Member's coverage ends.

We don't grant an extension if the Member voluntarily terminates his or her coverage. And what We pay is based on all the terms of this Policy.

B425.0093

COORDINATION OF BENEFITS (COB)

A Member may have dental coverage through multiple plans. When that occurs, one plan is determined to be primary while the other is deemed to be secondary.

Rules to make the primary/secondary determination are:

- The plan without a coordination provision is always primary.
- If a medical plan provides coverage for the dental service, that plan is primary. This excludes Affordable Care Act (ACA) compliant plans.
- If both plans have a COB provision, the plan providing coverage to an Employee is primary.
- A plan that provides coverage for an active Employee will be primary over a retiree plan.
- If a child is covered under both parents' plans:
  - When the parents are living together, the plan of the parent whose birthday is earlier in the year is primary.
  - When the parents are separated and not living together:
    - Any applicable court order will apply.
    - With 50/50 custody situations, the plan of the parent whose birthday is earlier in the year is primary.
    - With no court order benefits will be coordinated in the following order; (1) natural parent with custody; (2) step parent with custody; (3) natural parent without custody; and (4) step parent without custody.
- When none of these rules apply, the plan that has provided coverage the longest is primary.

When We are primary, benefits are determined as if no other plan exists.

B425.0096

Coordination with a Pre-Paid Dental Plan

A Member may also be covered under another pre-paid dental plan where they pay a fixed payment amount for each covered service. When the PCD participates under both pre-paid plans, the Member will never be responsible for more than the Patient Charge.

For Contracted Specialists' services, when this Policy is secondary, any payment made by the primary carrier is credited against the Patient Charge. In many cases the Member will have no out-of-pocket expenses.

B425.0097

Coordination with a PPO Dental Plan

When a Member is covered by this Policy and a fee-for-service plan, the following rules will apply:

- For PCD services: If this Policy is the primary plan, the PCD submits a claim to the secondary plan for the Patient Charge amount. Any payment made by the secondary carrier must be deducted from the Member's Patient Charge.
- For PCD services: If this Policy is the secondary plan, the PCD submits a claim to the primary plan for his or her usual or contracted fee. The primary plan's payment is then credited against the Patient Charge, reducing the Member's out-of-pocket expense.
- For Contracted Specialist services: If this Policy is the primary plan, benefits are paid as usual.
- For Contracted Specialist services: If this Policy is the secondary plan, any payment made by the primary carrier is credited against the Patient Charge, reducing the Member's out-of-pocket expense.

B425.0098

Our Right to Certain Information

In order to coordinate benefits, We need certain information. A Member must supply Us with as much information as he or she can. If he or she can't give Us all the information needed, We have the right to request this information from any source. If another carrier needs information to apply its coordination provision, We have the right to give that carrier such information. If We give or get information, We can't be held liable for such action except as required by law.

When payments that should have been made by this Policy have been made by another plan, We have the right to repay that plan. If We do so, We are no longer liable for that amount. If We pay out more than We should have, We have the right to recover the excess payment.

B425.0099

GRIEVANCE PROCESS

Member grievances are to be submitted to MDC's Quality of Care Liaison ("QCL") who processes the grievances. The QCL can be contacted at 1-800-273-3330 or by mail to P.O. Box 25256, Lehigh Valley, PA 18002-5256. The QLC hours are from 8:00 a.m. to 5:00 p.m. Pacific Time. Grievances may also be submitted on Our website at www.manageddentalcare.net.

The grievance process is designed to address Member concerns quickly and satisfactorily. It is generally recognized that grievances may be classified into two categories:

- Administrative Services: financial, accounting, procedural matters, coverage information such as effective dates, explanations of policy and Evidence of Coverage, claims, benefits and coverage, or benefit terms and definitions.
- Health Services: quality of care, access, availability, standards of care, appeal of denied second opinion requests, appeals of Specialty Referral decisions, professional and ethical considerations.

A grievance means any dissatisfaction expressed by a Member, orally or in writing, regarding MDC's operation, including but not limited, to Policy administration, denial of access to a specialty referral as services are covered at the general Dentist office, a determination that a procedure is not covered under the contract, an appeal of a denied second opinion request, the denial, reduction, or termination of a service, the way a service is provided, or disenrollment decisions. A grievance related to the denial of specialty care services for the lack of medical necessity will be handled by the grievance process. Where MDC cannot distinguish between an inquiry and a grievance, it shall be considered a grievance.

A grievance and a complaint are one and the same.

Coverage dispute means that a Member is not provided a covered service as a Policy benefit.

In order to be responsive to Member problems and concerns about coverage provided by MDC, the following grievance procedures have been established:

1. Questions or concerns may be directed to MDC either by telephone or by mail by the Member or Member's Designee ("Member"). When Member inquiries are received by telephone, the customer services representative documents the call and works with the Member to resolve the issue. If the issue is as an inquiry or complaint and is not a coverage dispute, a disputed dental care service involving medical necessity or experimental or investigational treatment, and that is resolved by the next business day following receipt, it may be handled by the customer services department. All other issues that are grievances will be documented on a grievance form by the customer services representative on behalf of the Member and the grievance form will be forwarded to the Quality of Care Liaison or Designee (QCL). The Member may be sent a grievance form to complete, if requested.

   When a Member who files a grievance or wants to file a grievance has a language barrier, cultural need or disability that requires special assistance, the Member Services Department will work with the QCL and provide accommodation, according to MDC guidelines.

2. Assistance in filing grievances shall be provided at each dental office as well as by MDC. Each dental office has a grievance form and a description of the grievance process readily available and will provide the form promptly upon request. The dental office will submit the grievance form to MDC at the Member's request.

3. Members may file a grievance up to 180 calendar days following any incident or action that is the subject of the dissatisfaction. In the case of a grievance alleging that the Member's coverage has been or will be improperly cancelled, rescinded, or not renewed, the 180 days begins on the date indicated on the Notice of Cancellation, Rescission, or Nonrenewal.

4. No later than five (5) calendar days after receipt of the grievance, or three (3) calendar days for grievances received via the MDC website, an acknowledgment letter is sent to the Member indicating the date the grievance was received, the name and telephone number of the QCL that a review is taking place and the grievance will be responded to within 30 days from the date of MDC's receipt of the grievance in a resolution letter.

5. Under the supervision of the QCL, supporting documentation is collected on the issue. The dental office may be requested to provide additional information, such as copies of all relevant dental records and radiographs, and statements of the Dentist or office personnel. MDC may arrange a second opinion, if appropriate.

6. Upon receipt of complete documentation, a resolution is determined based upon objective evaluation. A resolution letter will be sent to the Member within 30 calendar days from the date of MDC's receipt of the grievance. Quality of care issues or potential quality of care issues are resolved under the supervision of the Dental Director or designee (Dental Director). Issues of a complex nature and/or quality of care issues, at the discretion of the Dental Director, may be presented to the Grievance Committee or Peer Review Committee for review and resolution.

   The Dental Director reviews all quality of care or potential quality of care grievances at least biweekly and reviews and approves all letters of resolution that are sent to Members. The Dental Director will indicate his/her review of available documentation by initialing a copy of the resolution letter.

   The resolution letter to the Member will detail in a clear, concise manner the reasons for MDC's response. For grievances involving the delay, denial or modification of dental care services, the response letter shall describe the criteria used and the clinical reasons for its decision, including all criteria and clinical reasons related to medical necessity. If MDC, or one of its clinical reviewers, issues a determination delaying, denying or modifying dental care services based in whole or in part on a finding that the proposed dental care services are not a covered benefit under the Policy that applies to the Member, the letter shall clearly specify the provisions in the Policy that exclude that coverage. In the event that an MDC grievance involves the delay, modification or denial of a covered service due to medical necessity, the resolution letter will include an IMR application and a Department of Managed Health Care addressed envelope.

B425.1260

7. Within thirty (30) calendar days following receipt of a resolution letter, a Member, or Member's Designee, may also request voluntary mediation with MDC prior to exercising the right to submit a grievance to the Department of Managed Health Care. Additional time may be requested due to a Member's extraordinary circumstance. The use of mediation services shall not preclude the right to submit a grievance to the Department of Managed Health Care. In order to initiate mediation, the Member or the Member's Designee and MDC shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process authorized by this paragraph.

   Following the use of the voluntary mediation process, the Member and MDC each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by a Dentist.

8. A grievance may be submitted to the Department of Managed Health Care for review and resolution prior to any arbitration.

9. 9.Members shall not be required to complete the grievance process, or participate in the process for at least thirty (30) calendar days before submitting a complaint to the Department of Managed Health Care in any case determined by the Department of Managed Health Care to be a case involving an imminent and serious threat to the health of the patient, including but not limited to severe pain, the potential loss of life, limb or major bodily function; for any case involving cancellation, rescission, or nonrenewal of coverage; or in any other case where the Department of Managed Health Care determines that an earlier review is warranted.

10. MDC shall keep all copies of grievances, and the responses to grievances, for a period of five years.

11. MDC's Secretary, who is an officer of the plan, or designee, has primary responsibility for MDC's grievance system.

12. A written record of office specific and aggregate tabulated grievances will be maintained for each grievance received by MDC and that record will be reviewed quarterly by the Dental Director, the Quality Assurance Committee, the Public Policy Committee and the Board of Directors.

13. MDC asserts that there is no discrimination against a Member (including cancellation of the contract) solely on the grounds that the Member filed a complaint.

    The Department of Managed Health Care may contact MDC's Quality Management Staff regarding urgent grievances every business day from 8:00 am to 5:00 pm by calling 1-800-273-3330. For urgent grievances received from the Department of Managed Health Care during business hours, MDC will respond within 30 minutes. For urgent grievances after business hours, The Department of Managed Health Care should contact MDC's staff in the following order:

14. Dental Director/Plan Officer Responsible for Grievances at 1-310-908-1917, Quality of Care Liaison at 1-818-437-4177, and President at 1-207-210-8727. For urgent grievance calls received after hours, the above listed personnel will respond to the Department of Managed Health Care within one (1) hour after initial contact. Within one (1) business day of receipt of the Department of Managed Health Care's notice of acceptance of a proper complaint related to the cancellation, rescission, or nonrenewal of a Member's coverage, MDC shall respond and provide the Department of Managed Health Care with a copy of all information MDC used to makes its termination of coverage determination and all other relevant information necessary for the Department of Managed Health Care's review.

Grievances Requiring Expedited Review

MDC will review grievances on an expedited basis when the grievances involve an imminent and serious threat to the health of the Member, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. They may also include, but are not limited to, procedures administered in a hospital, Dentist's office, dental clinic, or other comparable facility, to evaluate and stabilize dental conditions of a recent onset and severity accompanied by excessive bleeding, severe pain, acute infection, fever, swelling or to prevent the imminent loss of teeth that would lead a prudent layperson possessing an average knowledge of dentistry to believe that immediate care is needed and which are covered under the Policy.

MDC shall also conduct expedited review of grievances concerning the cancellation, rescission, or nonrenewal of coverage.

When MDC has notice of a grievance requiring expedited review, the grievance process requires MDC to immediately inform Members in writing of their right to notify the Department of Managed Health Care of the grievance. MDC also will provide Members and the Department of Managed Health Care with a written statement on the disposition or pending status of the grievance no later than three days from receipt of the grievance. MDC shall consider the Member's medical condition when determining the response time for an expedited grievance.

If the Member files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, MDC shall continue to provide coverage to the Member pursuant to the terms of the Member's Policy while the grievance is pending with MDC and/or the Department of Managed Health Care.

The following grievance disclosure will be on all Member correspondence:

Disclosure:

With respect to certain actions that impact You and Your coverage, Managed Dental Care or Your Employer will provide You with notice:

- When premium has not been paid and Your coverage is in force due solely to the Policy's Grace Period;
- When this Policy or Your coverage under this Policy is rescinded due to certain contractual provisions; or
- When this Policy is terminated for any other reason as may be allowed by the Policy.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-273-3330** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance

involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms, and instructions online.

You may also access grievance forms at Managed Dental Care's website at **www.manageddentalcare.net.** Click on the "GRIEVANCE FORM" Portal box or may be obtained by contacting MDC's Customer Care Team at (800) 273-3330.

Note: Free language assistance services are available for You and Your dependents to assist with Your dental needs. Please contact Managed Dental Care's Member Services Department at 1-800-273-3330, Your assigned network general dentist or Your network specialist (for Managed Dental Care's approved specialty care) if English is not Your or Your dependents preferred spoken or written language.

Nota: Los servicios gratuitos de ayuda con el idioma estan disponibles para usted y sus dependientes para ayudarle con sus necesidades dentales. Si el inglis no es el idioma preferido de usted o sus dependientes, por favor comunmquese a nuestro Departamento de Servicios para Miembros al 1-800-273-3330, su dentista general de red asignada o su especialista de red (para una atencisn especializada de Managed Dental Care).

B425.1226

Covered Services

MDC covers diagnostic, preventive, restorative, endodontic, periodontic, removable prosthodontics, fixed prosthodontics, oral surgery, orthodontics and adjunctive general as well as specialist and Emergency Dental Services. Covered services will be provided as necessary for a Member's dental health consistent with professionally recognized standards of practice, subject to the limitations and exclusions described in connection with each category of covered services.

Covered services include:

DIAGNOSTIC

- Clinical Oral Evaluations
- Radiographs (X-rays)
- Tests and Examinations

* A complete list of covered diagnostic services is listed in the Schedule of Benefits.

PREVENTIVE

- Prophylaxis (cleaning)
- Topical Fluoride
- Space Maintainers

* A complete list of covered preventive services is listed in the Schedule of Benefits.

RESTORATIVE

- Amalgam (silver fillings)
- Resin Based Composite (white fillings)
- Inlays
- Onlays
- Crowns
- Other Restorative Services

* A complete list of covered restorative services is listed in the Schedule of Benefits.

ENDODONTICS

- Pulp Capping
- Pulpotomy
- Endodontic Therapy (root canals)
- Endodontic Retreatment
- Apicoectomy/Periradicular Services

* A complete list of covered endodontic services is listed in the Schedule of Benefits.

PERIODONTICS

- Surgical Services
- Non-Surgical Services

* A complete list of covered periodontic services is listed in the Schedule of Benefits.

PROSTHODONTICS
(Removable)

- Complete Dentures
- Partial Dentures
- Adjustments to Dentures
- Repairs
- Rebase
- Reline

* A complete list of covered prosthodontics (removable) services is listed in the Schedule of Benefits.

PROSTHODONTICS
(Fixed)

- Fixed Partial Denture Pontics
- Fixed Partial Denture Retainers - Crowns

* A complete list of covered prosthodontics (fixed) services is listed in the Schedule of Benefits.
Note: Treatment which requires the services of a Prosthodontist are not covered.

ORAL SURGERY

- Surgical Extractions
- Other Surgical Procedures
- Alveoloplasty
- Surgical Excision of Intra-Osseous Lesions
- Surgical Incision

* A complete list of covered oral surgery services is listed in the Schedule of Benefits.

ORTHODONTICS

- Orthodontic Treatment

* A complete list of covered orthodontic services is listed in the Schedule of Benefits.

ADJUNCTIVE GENERAL SERVICES

- Palliative Treatment
- Professional Consultations
- Professional Visits

* A complete list of covered adjunctive general services is listed in the Schedule of Benefits.

A list of the services covered by this Policy, including Patient Charges is provided in the section Schedule of Benefits.

Exclusions and limitations will apply to some of the services. Refer to the Benefit Limitations, Additional Conditions and Exclusions sections of the Schedule of Benefits.

B425.1227

DEFINITIONS

This section defines certain terms appearing in Your Evidence of Coverage.

B425.0712

Act: This term means the Knox-Keene Health Care Service Plan of 1975 (California Health and Safety Code Sections 1340 et seq).

B425.0713

Active Work or Actively At Work or Actively Working: These terms mean You are able to perform, and are performing, all of the regular duties of Your work for the Employer, at:

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

B425.0102

Alternative Procedure: This term means a procedure other than that recommended by the Member's Primary Care Dentist, but which in the opinion of the Primary Care Dentist also represents an acceptable treatment approach for the Member's dental condition.

B425.0103

Code: This term means the California Health and Safety Code.

B425.0714

Combined Evidence of Coverage and Disclosure Form: This term means this booklet issued to You, which summarizes the essential terms of this Policy.

B425.0724

Contracted Dentist: This term means a licensed Dentist or a dental care facility that is under contract with Us to participate in Our dental Network.

B425.0105

Contracted General Dentist: This term means a licensed dentist under contract with Us who is listed in Our directory of Contracted Dentists as a general practice dentist and who may be selected as a Primary Care Dentist by a Member.

B425.0106

Contracted Specialist: This term means a licensed Dentist under contract with Us as an endodontist, oral surgeon, orthodontist, pediatric dentist or periodontist.

B425.0107

Dentist and Dentists: This term means any dental or medical practitioner We are required by law to recognize who: (1) is properly licensed or certified under the laws of the state where he or she practices; and (2) provides services which are within the scope of his or her license or Evidence of Coverage and covered by this Policy.

B425.0715

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

B425.0717

Eligibility Date: This term means the earliest date You are eligible for coverage under this Evidence of Coverage as directed by the Employer, and you have satisfied all requirements for coverage to begin, as required by this Evidence of Coverage.

B425.0719

Emergency Dental Service: This term means services which are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding or severe discomfort or to prevent the imminent loss of teeth.

B425.0113

Evidence of Coverage: This term means this certificate of coverage, including the Schedule of Benefits and any riders and enrollment forms that may be attached to this Evidence of Coverage.

B425.0720

Full-time: This term means:

You are not a Part-time Employee as defined by Your Employer and You work at least the minimum required number of hours for the Employee in Your eligible class (but not less than 30 hours per week) at:

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

B425.0116

Member: This term means You, if You are covered by this Policy, and any of Your covered dependents.

B425.0118

Network: This term means The Managed Dental Care network.

B425.0120

Non-Contracted Dentist: This term means a licensed Dentist or dental care facility that is not under contract with Us to provide dental services to Employees in Our benefit Policy.

B425.0122

Patient Charge: This term means the amount the Member is responsible for. Patient Charge amounts are listed under the Covered Dental Procedures and Patient Charges section of the Schedule of Benefits.

B425.0123

Policy: This term means the Group Dental Coverage described in the Policy and this Evidence of Coverage.

B425.0721

Policyholder: This term means an Employer that is offering benefits to a Member under this Policy.

B425.0125

Primary Care Dentist (PCD): This term means a Contracted General Dentist selected by a Member who is responsible for providing or arranging for a Member's dental services.

B425.0126

Prior Carrier's Group Dental Policy: This term means the Employer's Policy of group dental coverage which was in force immediately prior to this Policy. For a Policy to be considered a Prior Policy, the Policy with Us must start immediately after the prior coverage ends.

B425.0128

Qualifying Event: This term means a specific occurrence that changes a Member's eligibility status such as Your Spouse's loss of employment; Your Spouse's loss of eligibility under his or her dental Policy; divorce; death of Your Spouse; termination of another dental Policy; or any other event as required by state or federal law or in accordance with Your Employer's rules.

B425.0130

Service Area: This term means the geographic area in which We have arranged to provide for dental services for Members.

B425.0131

Sensitive Services: This term means covered services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence.

B425.1225

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

B425.1050

We, Us, Our and MDC: These terms mean Managed Dental Care of California.

You or **Your** or **Yourself:** These terms mean the covered Employee.

B425.0723

STATEMENT OF ERISA RIGHTS

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

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

ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Prudent Actions By Plan Fiduciaries

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

Enforcement Of Your Rights

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

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

Assistance with Questions

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

Qualified Medical Child Support Order and Qualified Domestic Relations Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A dependent child also includes a child for whom You must provide Dental Insurance due to a QMCSO as defined in the ERISA Section 609(a) United States Employee Retirement Income Security Act of 1974, as amended.

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

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

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

Dental Benefits Claims Procedure

Claim forms and instructions for filing claims may be obtained from The Guardian Life Insurance Company of America (hereinafter referenced as Guardian).

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

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

B425.0167

Definitions

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

Timing For Initial Benefit Determination

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

In reviewing an appeal, Guardian will:

- Provide for a review conducted by a named fiduciary who is neither the person who made the initial Adverse Benefit Determination nor that person's subordinate;
- In deciding an appeal based upon a dental or medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- Identify dental or medical experts whose advice was obtained in connection with an Adverse Benefit Determination; and

- Ensure that a health care professional engaged for consultation regarding an appeal based upon a professional judgment shall be neither the person who was consulted in connection with the Adverse Benefit Determination, nor that person's subordinate.

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

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

In the event Guardian denies the appeal of an Adverse Benefit Determination, it will:

- Provide the specific reason or reasons why the appeal was denied;
- Refer to the specific provisions in the Policy, Certificate, plan, or other documents on which the benefit determination is based;
- Provide a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- If applicable, provide the internal rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

Alternative Dispute Options

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

B425.0168

Managed Dental Care
6255 Sterners Way
Bethlehem, PA 18017
1-800-273-3330

GROUP DENTAL COVERAGE

SCHEDULE OF BENEFITS

The Schedule of Benefits provides dental benefit information. This schedule lists the procedures covered by this Policy, as well as the Patient Charges, Benefit Limitations, Additional Conditions and the Exclusions. Please read the entire Certificate of Coverage, along with this Schedule of Benefits, to fully understand all the terms, conditions, limitations and exclusions that apply.

B425.1259

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - N300

The procedures covered by the Policy are named in this list. If a procedure is not on this list, it is not covered. All procedures must be provided by the assigned Primary Care Dentist (PCD) or by referral to a Contracted Specialist.

A Member must pay the listed Patient Charge. The benefits We provide are subject to all of the terms of the Policy, including the Benefit Limitations, Additional Conditions and Exclusions.

A Member may be charged a Patient Charge for a missed appointment or a cancelled appointment if the dental office is not given at least 24 hours' notice of cancellation.

The Patient Charges listed are only valid for covered procedures that are: (1) started and completed under the Policy, and (2) rendered by Contracted Dentists.

B425.1052

COVERED DENTAL PROCEDURES AND PATIENT CHARGES - PLAN N300

CDT CODE **Current Dental Terminology (CDT) © American Dental Association (ADA)**

CDT CODE	COVERED DENTAL PROCEDURES	PATIENT CHARGE
	D0100-D0999 DIAGNOSTICS	
D0999	Office visit during regular hours, General Dentist only	$5
D0120	Periodic oral evaluation - established patient	$0
D0140	Limited oral evaluation - problem focused	$0
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	$0
D0150	Comprehensive oral evaluation - new or established patient	$0
D0160	Detailed and extensive oral evaluation - problem focused by report	$0
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0
D0171	Re-evaluation - post-operative office visit	$0
D0180	Comprehensive periodontal evaluation - new or established patient	$0
D0190	Screening of a patient	$0
D0191	Assessment of a patient	$0
D0210	Intraoral - complete series of radiographic images	$0
D0220	Intraoral - periapical first radiographic image	$0
D0230	Intraoral - periapical each additional radiographic image	$0
D0240	Intraoral - occlusal radiographic image	$0
D0250	Extra-oral - 2D projection radiographic image created using a stationary radiation source, and detector	$0
D0270	Bitewing - single radiographic image	$0
D0272	Bitewings - two radiographic images	$0
D0273	Bitewings - three radiographic images	$0
D0274	Bitewings - four radiographic images	$0
D0277	Vertical bitewings - 7 to 8 radiographic images	$0
D0330	Panoramic radiographic image	$0
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	$0
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	$0
D0364	Cone beam CT capture and interpretation with limited field of view - less than one whole jaw	Not Covered
D0365	Cone beam CT capture and interpretation with field of view of one full dental arch - mandible	Not Covered
D0366	Cone beam CT capture and interpretation with field of view of one full dental arch - maxilla, with or without cranium	Not Covered
D0367	Cone beam CT capture and interpretation with field of view of both jaws; with or without cranium	Not Covered
D0415	Collection of microorganisms for culture and sensitivity	$0
D0425	Caries susceptibility tests	$0

D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$35
D0460	Pulp vitality tests	$0
D0470	Diagnostic casts	$0
D0472	Accession of tissue, gross examination, preparation and transmission of written report	$0
D0473	Accession of tissue, gross and microscopic examination, preparation and transmission of written report	$0
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	$0
D0480	Accession of exfoliative cytologic smears, microscopic examination preparation and transmission of written report	$0
D0486	Laboratory accession of transepithelial cytologic sample, microscopic examination preparation and transmission of written report	$0
D0502	Other oral pathology procedures, by report	$0

D1000-D1999 PREVENTIVE

D1110	Prophylaxis - adult, for the first two procedures in any 12 month period	$0
D1120	Prophylaxis - child, for the first two procedures in any 12 month period	$0
D1999	Prophylaxis - adult or child, for each additional procedure in the same 12 month period (maximum of 2 additional in the same 12 month period)	$35
M1110	Prophylaxis - One additional prophylaxis in any 12 month period will be covered at no charge for Members who: (a) are pregnant and in their 2nd or 3rd trimester; (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis.	$0
D1206	Topical application of fluoride varnish, for the first two procedures in any 12 month period	$0
D1208	Topical application of fluoride - excluding varnish, for the first two procedures in any 12 month period	$0
D2999	Topical fluoride each additional procedure in same 12 month period	$20
D1310	Nutritional counseling for control of dental disease	$0
D1320	Tobacco counseling for the control and prevention of oral disease	$0
D1330	Oral hygiene instructions	$0
D1351	Sealant - per tooth - molars	$8
D9999	Sealant - per tooth - non-molars	$35
D1352	Preventive resin restoration in a moderate to high caries risk patient - permanent tooth	$8
D1353	Sealant repair - per tooth	$5
D1510	Space maintainer - fixed - unilateral	$65
D1515	Space maintainer - fixed - bilateral	$85
D1520	Space maintainer - removable - unilateral	$65
D1525	Space maintainer - removable - bilateral	$85
D1550	Re-cement or re-bond space maintainer	$10
D1555	Removal of fixed space maintainer	$20

B425.0832

D2000-D2999 RESTORATIVE

D2140	Amalgam - one surface, primary or permanent	$8
D2150	Amalgam - two surfaces, primary or permanent	$12
D2160	Amalgam - three surfaces, primary or permanent	$14
D2161	Amalgam - four or more surfaces, primary or permanent	$17
D2330	Resin-based composite - one surface, anterior	$20
D2331	Resin-based composite - two surfaces, anterior	$28
D2332	Resin-based composite - three surfaces, anterior	$32
D2335	Resin-based composite - four or more surfaces or involving incisal angle, (anterior)	$45
D2390	Resin-based composite crown, anterior	$60
D2391	Resin-based composite - one surface, posterior	$28
D2392	Resin-based composite - two surfaces, posterior	$35
D2393	Resin-based composite - three surfaces, posterior	$40
D2394	Resin-based composite - four or more surfaces, posterior	$60
D2510	Inlay - metallic - one surface**	$285
D2520	Inlay - metallic - two surfaces **	$320
D2530	Inlay - metallic - three or more surfaces**	$375
D2542	Onlay - metallic - two surfaces **	$375
D2543	Onlay - metallic - three surfaces**	$400
D2544	Onlay - metallic - four or more surfaces**	$420
D2610	Inlay - porcelain/ceramic - one surface	$285
D2620	Inlay - porcelain/ceramic - two surfaces	$320
D2630	Inlay - porcelain/ceramic - three or more surfaces	$330
D2642	Onlay - porcelain/ceramic - two surfaces	$375
D2643	Onlay - porcelain/ceramic - three surfaces	$400
D2644	Onlay - porcelain/ceramic - four or more surfaces	$410
D2650	Inlay - resin-based composite - one surface	$250
D2651	Inlay - resin-based composite - two surfaces	$295
D2652	Inlay - resin-based composite - three or more surfaces	$315
D2662	Onlay - resin-based composite - two surfaces	$295
D2663	Onlay - resin-based composite - three surfaces	$315
D2664	Onlay - resin-based composite - four or more surfaces	$350
D2710	Crown - resin-based composite (indirect)	$225
D2712	Crown - 3/4 resin-based composite (indirect)	$225
D2720	Crown - resin with high noble metal**	$250
D2721	Crown - resin with predominantly base noble	$250
D2722	Crown - resin with noble metal	$250
D2740	Crown - porcelain/ceramic substrate	$425
D2750	Crown - porcelain fused to high noble metal**	$375
D2751	Crown - porcelain fused to predominantly base metal	$375
D2752	Crown - porcelain fused to noble metal	$375
D2780	Crown - 3/4 cast high noble metal**	$365
D2781	Crown - 3/4 cast predominantly base metal	$365
D2782	Crown - 3/4 cast noble metal	$365
D2783	Crown - 3/4 porcelain/ceramic	$365
D2790	Crown - full cast high noble metal**	$375
D2791	Crown - full cast predominantly base metal	$375
D2792	Crown - full cast noble metal	$375
D2794	Crown - titanium	$375

D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$16
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$16
D2920	Re-cement or re-bond crown	$16
D2929	Prefabricated porcelain/ceramic crown - primary tooth	$115
D2930	Prefabricated stainless steel crown - primary tooth	$88
D2931	Prefabricated stainless steel crown - permanent tooth	$88
D2932	Prefabricated resin crown	$108
D2933	Prefabricated stainless steel crown with resin window	$108
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$115
D2940	Protective restoration	$20
D2941	Interim therapeutic restoration - primary dentition	$15
D2949	Restorative foundation for an indirect restoration	$0
D2950	Core buildup, including any pins when required	$90
D2951	Pin retention - per tooth, in addition to restoration	$18
D2952	Post and core in addition to crown, indirectly fabricated	$140
D2953	Each additional indirectly fabricated post - same tooth	$45
D2954	Prefabricated post and core in addition to crown	$125
D2955	Post removal	$85
D2957	Each additional prefabricated post - same tooth	$25
D2960	Labial veneer (resin laminate) - chairside	$235
D2961	Labial veneer (resin laminate) - laboratory	$275
D2962	Labial veneer (porcelain laminate) - laboratory	$350
D2971	Additional procedures to construct new crown under existing partial denture framework	$125
D2980	Crown repair necessitated by restorative material failure	$90
D2981	Inlay repair necessitated by restorative material failure	$80
D2982	Onlay repair necessitated by restorative material failure	$85
D2983	Veneer repair necessitated by restorative material failure	$80
D2990	Resin infiltration of incipient smooth surface lesions	$25

D3000-D3999 ENDODONTICS

D3110	Pulp cap - direct (excluding final restoration)	$12
D3120	Pulp cap - indirect (excluding final restoration)	$12
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$35
D3221	Pulpal debridement, primary and permanent teeth	$35
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$35
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$46
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$70
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$120
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$140
D3330	Endodontic therapy, molar (excluding final restoration)	$180
D3331	Treatment of root canal obstruction; non-surgical access	$52

D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$110
D3333	Internal root repair or perforation defects	$116
D3346	Retreatment of previous root canal therapy - anterior	$325
D3347	Retreatment of previous root canal therapy - bicuspid	$335
D3348	Retreatment of previous root canal therapy - molar	$380
D3351	Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root restoration, etc.)	$45
D3352	Apexification/recalcification - interim medication replacement	$35
D3353	Apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root restoration, etc.)	$95
D3410	Apicoectomy - anterior	$240
D3421	Apicoectomy - bicuspid (first root)	$270
D3425	Apicoectomy - molar (first root)	$335
D3426	Apicoectomy - (each additional root)	$95
D3427	Periadicular surgery without apicoectomy	$270
D3430	Retrograde filling - per root	$73
D3450	Root amputation - per root	$100
D3920	Hemisection (including any root removal), not including root canal therapy	$95
D3950	Canal preparation and fitting of preformed dowel or post	$20

B425.0186

D4000-D4999 PERIODONTICS

D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$125
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$60
D4212	Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	$40
D4240	Gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	$240
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	$140
D4245	Apically positioned flap	$175
D4249	Clinical crown lengthening - hard tissue	$200
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$380
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$230
D4263	Bone replacement graft - first site in quadrant	$180
D4264	Bone replacement graft - each additional site in quadrant	$105
D4266	Guided tissue regeneration - resorbable barrier, per site	$175
D4267	Guided tissue regeneration - non-resorbable barrier, per site (includes membrane removal)	$175
D4268	Surgical revision procedure, per tooth	$0
D4270	Pedicle soft tissue graft procedure	$254

D4273	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position.	$275
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	$125
D4275	Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft	$285
D4276	Combined connective tissue and double pedicle graft, per tooth	$285
D4277	Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft	$270
D4278	Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	$175
D4283	Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	$188
D4285	Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in the same graft site	$165
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$50
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$34
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	$60
D4910	Periodontal maintenance	$27
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$25
D4921	Gingival irrigation - per quadrant	$35
D4999	Periodontal maintenance, for each additional procedure in same 12 month period (maximum of 2 additional in the same 12 month period)	$60

D5000-D5899 PROSTHODONTICS - REMOVABLE

D5110	Complete denture - maxillary	$452
D5120	Complete denture - mandibular	$452
D5130	Immediate denture - maxillary	$492
D5140	Immediate denture - mandibular	$492
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$443
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$443
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$500
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$500

D5221	Immediate maxillary partial denture - resin base (including any conventional clasps, rests and teeth	$465
D5222	Immediate mandibular partial denture - resin base (including any conventional clasps, rests and teeth	$465
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$525
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$525
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$575
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$575
D5281	Removable unilateral partial denture - one piece cast metal (including clasps and teeth)	$160
D5410	Adjust complete denture - maxillary	$23
D5411	Adjust complete denture - mandibular	$23
D5421	Adjust partial denture - maxillary	$23
D5422	Adjust partial denture - mandibular	$23
D5510	Repair broken complete denture base	$50
D5520	Replace missing or broken teeth - complete denture (each tooth)	$36
D5610	Repair resin denture base	$45
D5620	Repair cast framework	$85
D5630	Repair or replace broken clasp - per tooth	$60
D5640	Replace broken teeth - per tooth	$36
D5650	Add tooth to existing partial denture	$52
D5660	Add clasp to existing partial denture - per tooth	$64
D5670	Replace all teeth and acrylic on cast metal framework (maxillary)	$196
D5671	Replace all teeth and acrylic on cast metal framework (mandibular)	$196
D5710	Rebase complete maxillary denture	$160
D5711	Rebase complete mandibular denture	$160
D5720	Rebase maxillary partial denture	$160
D5721	Rebase mandibular partial denture	$160
D5730	Reline complete maxillary denture (chairside)	$88
D5731	Reline complete mandibular denture (chairside)	$88
D5740	Reline maxillary partial denture (chairside)	$88
D5741	Reline mandibular partial denture (chairside)	$88
D5750	Reline complete maxillary denture (laboratory)	$120
D5751	Reline complete mandibular denture (laboratory)	$120
D5760	Reline maxillary partial denture (laboratory)	$120
D5761	Reline mandibular partial denture (laboratory)	$120
D5810	Interim complete denture (maxillary)	$418
D5811	Interim complete denture (mandibular)	$418
D5820	Interim partial denture (maxillary)	$180
D5821	Interim partial denture (mandibular)	$180
D5850	Tissue conditioning, maxillary	$36
D5851	Tissue conditioning, mandibular	$36

B425.0187

D6000-D6199 IMPLANT SERVICES

D6010	Surgical placement of implant body: endosteal implant	Not Covered
D6011	Second stage implant surgery	Not Covered
D6055	Connecting bar - implant supported or abutment supported	Not Covered
D6056	Prefabricated abutment - includes modification and placement	Not Covered
D6057	Custom fabricated abutment - includes placement	Not Covered
D6058	Abutment supported porcelain/ceramic crown	Not Covered
D6059	Abutment supported porcelain fused to metal crown (high noble metal)**	Not Covered
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	Not Covered
D6061	Abutment supported porcelain fused to metal crown (noble metal)	Not Covered
D6062	Abutment supported cast metal crown (high noble metal)**	Not Covered
D6063	Abutment supported cast metal crown (predominantly base metal)	Not Covered
D6064	Abutment supported cast metal crown (noble metal)	Not Covered
D6065	Implant supported porcelain/ceramic crown	Not Covered
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)**	Not Covered
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)**	Not Covered
D6068	Abutment supported retainer for porcelain/ceramic FPD	Not Covered
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)**	Not Covered
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	Not Covered
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	Not Covered
D6072	Abutment supported retainer for cast metal FPD (high noble metal)**	Not Covered
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	Not Covered
D6074	Abutment supported retainer for cast metal FPD (noble metal)	Not Covered
D6075	Implant supported retainer for ceramic FPD	Not Covered
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)**	Not Covered
D6077	Implant supported retainer for cast FPD (titanium, titanium alloy, or high noble metal)**	Not Covered
D6092	Re-cement or re-bond implant/abutment supported crown	Not Covered
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	Not Covered
D6094	Abutment supported crown (titanium)	Not Covered
D6101	Debridement of a peri-implant defect or defects surrounding a single implant, and surface cleaning of the exposed implant, surfaces, including flap entry and closure	Not Covered

D6102	Debridement and osseous contouring of a peri-implant defect or defects surrounding a single implant and includes surface cleaning of the exposed implant surfaces, including flap entry and closure	Not Covered
D6103	Bone graft for repair of peri-implant defect - does not include flap entry and closure	Not Covered
D6104	Bone graft at time of implant placement	Not Covered
D6110	Implant/abutment supported removable denture for edentulous arch - maxillary	Not Covered
D6111	Implant/abutment supported removable denture for edentulous arch - mandibular	Not Covered
D6112	Implant/abutment supported removable denture for partially edentulous arch - maxillary	Not Covered
D6113	Implant/abutment supported removable denture for partially edentulous arch - mandibular	Not Covered
D6114	Implant/abutment supported fixed denture for edentulous arch - maxillary	Not Covered
D6115	Implant/abutment supported fixed denture for edentulous arch - mandibular	Not Covered
D6116	Implant/abutment supported fixed denture for partially edentulous arch - maxillary	Not Covered
D6117	Implant/abutment supported fixed denture for partially edentulous arch - mandibular	Not Covered
D6190	Radiographic/surgical implant index, by report	Not Covered
D6194	Abutment supported retainer crown for FPD (titanium)	Not Covered

B425.0176

D6200-D6999 PROSTHODONTICS - FIXED

D6205	Pontic - indirect resin based composite	$135
D6210	Pontic - cast high noble metal**	$375
D6211	Pontic - cast predominantly base metal	$375
D6212	Pontic - cast noble metal	$375
D6214	Pontic - titanium	$375
D6240	Pontic - porcelain fused to high noble metal**	$375
D6241	Pontic - porcelain fused to predominantly base metal	$375
D6242	Pontic - porcelain fused to noble metal	$375
D6245	Pontic - porcelain/ceramic	$425
D6250	Pontic - resin with high noble metal**	$250
D6251	Pontic - resin with predominantly base metal	$250
D6252	Pontic - resin with noble metal	$250
D6545	Retainer - cast metal for resin bonded fixed prosthesis	$350
D6548	Retainer - porcelain/ceramic for resin bonded fixed prosthesis	$360
D6600	Retainer inlay - porcelain/ceramic, two surfaces	$320
D6601	Retainer inlay - porcelain/ceramic, three or more surfaces	$400
D6602	Retainer inlay - cast high noble metal, two surfaces**	$320
D6603	Retainer inlay - cast high noble metal, three or more surfaces**	$400
D6604	Retainer inlay - cast predominantly base metal, two surfaces	$320

D6605	Retainer inlay - cast predominantly base metal, three or more surfaces	$400
D6606	Retainer inlay - cast noble metal, two surfaces	$320
D6607	Retainer inlay - cast noble metal, three or more surfaces	$400
D6608	Retainer onlay - porcelain/ceramic, two surfaces	$375
D6609	Retainer onlay - porcelain/ceramic, three or more surfaces	$300
D6610	Retainer onlay - cast high noble metal, two surfaces**	$375
D6611	Retainer onlay - cast high noble metal, three or more surfaces **	$400
D6612	Retainer onlay - cast predominantly base metal, two surfaces	$375
D6613	Retainer onlay - cast predominantly base metal, three or more surfaces	$400
D6614	Retainer onlay - cast noble metal, two surfaces	$375
D6615	Retainer onlay - cast noble metal, three or more surfaces	$400
D6624	Retainer inlay - titanium	$320
D6634	Retainer onlay - titanium	$350
D6710	Retainer crown - indirect resin based composite	$225
D6720	Retainer crown - resin with high noble metal **	$250
D6721	Retainer crown - resin with predominantly base metal	$250
D6722	Retainer crown - resin with noble metal	$250
D6740	Retainer crown - porcelain/ceramic	$425
D6750	Retainer crown - porcelain fused to high noble metal **	$375
D6751	Retainer crown - porcelain fused to predominantly base metal	$375
D6752	Retainer crown - porcelain fused to noble metal	$375
D6780	Retainer crown - 3/4 cast high noble metal **	$365
D6781	Retainer crown - 3/4 cast predominantly base metal	$365
D6782	Retainer crown - 3/4 cast noble metal	$365
D6783	Retainer crown - 3/4 porcelain/ceramic	$365
D6790	Retainer crown - full cast high noble metal **	$375
D6791	Retainer crown - full cast predominantly base metal	$375
D6792	Retainer crown - full cast noble metal	$375
D6794	Retainer crown - titanium	$375
D6930	Re-cement or re-bond fixed partial denture	$16
D6940	Stress breaker	$100
D6980	Fixed partial denture repair necessitated by restorative material failure	$85
D6999	Multiple crown and fixed partial denture retainers (bridge) treatment plan - per unit, six or more	$125

D7000-D7999 ORAL AND MAXILLOFACIAL SURGERY

D7111	Extraction - coronal remnants - deciduous tooth	$12
D7140	Extraction - erupted tooth or exposed root (elevation and/or forceps removal)	$15
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$40
D7220	Removal of impacted tooth - soft tissue	$70
D7230	Removal of impacted tooth - partially bony	$80
D7240	Removal of impacted tooth - completely bony	$110
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$140

D7250	Surgical removal of residual tooth roots (cutting procedure)	$35
D7251	Coronectomy - intentional partial tooth removal	$110
D7260	Oroantral fistula closure	$215
D7261	Primary closure of a sinus perforation	$255
D7270	Tooth re-implantation and/or stabilization of accidentally evulsed or displaced tooth	$160
D7280	Surgical access of an unerupted tooth	$210
D7282	Mobilization of erupted or malpositioned tooth to aid eruption	$210
D7283	Placement of device to facilitate eruption of impacted tooth	$50
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$95
D7286	Incisional biopsy of oral tissue - soft	$70
D7287	Exfoliative cytological sample collection	$60
D7288	Brush biopsy - transepithelial sample collection	$65
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$40
D7310	Alveoloplasty, in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$65
D7311	Alveoloplasty, in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$40
D7320	Alveoloplasty, not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85
D7321	Alveoloplasty, not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$70
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$235
D7471	Removal of lateral exostosis (maxilla or mandible)	$224
D7472	Removal of torus palatinus	$224
D7473	Removal of torus mandibularis	$224
D7485	Surgical reduction of osseous tuberosity	$224
D7510	Incision and drainage of abscess - intraoral soft tissue	$35
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$60
D7520	Incision and drainage of abscess - extraoral soft tissue	$65
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70
D7953	Bone replacement graft for ridge preservation - per site	$170
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$115
D7963	Frenuloplasty	$170
D7970	Excision of hyperplastic tissue - per arch	$85
D7971	Excision of pericoronal gingiva	$65
D7972	Surgical reduction of fibrous tuberosity	$128

B425.0188

D8000-D8999 ORTHODONTICS

D8010	Limited orthodontic treatment of the primary dentition	$700
D8020	Limited orthodontic treatment of the transitional dentition	$700
D8030	Limited orthodontic treatment of the adolescent dentition	$700
D8040	Limited orthodontic treatment of the adult dentition	$700
D8050	Interceptive orthodontic treatment of the primary dentition	$900

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D8060	Interceptive orthodontic treatment of the transitional dentition	$900
D8070	Comprehensive orthodontic treatment of the transitional dentition	$1,895
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,895
D8090	Comprehensive orthodontic treatment of the adult dentition	$2,195
D8660	Pre-orthodontic treatment examination to monitor growth and development (includes treatment plan, records, evaluation and consultation)	$250
D8670	Periodic orthodontic treatment visit	$0
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$400
D8681	Removable orthodontic retainer adjustment	$0

B425.1231

D9000-D9999 ADJUNCTIVE GENERAL SERVICES

D9110	Palliative (emergency) treatment of dental pain - minor procedure	$20
D9120	Fixed partial denture sectioning	$20
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$0
D9211	Regional block anesthesia	$0
D9212	Trigeminal division block anesthesia	$0
D9215	Local anesthesia in conjunction with operative or surgical procedures	$0
D9219	Evaluation for deep sedation or general anesthesia	$55
D9223	Deep sedation/general anesthesia - each 15 minute increment	$98
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	$25
D9243	Intravenous moderate (conscious) sedation/analgesia - each 15 minute increment	$40
D9248	Non-intravenous conscious sedation	$75
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$30
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0
D9440	Office visit - after regularly scheduled hours	$50
D9450	Case presentation, detailed and extensive treatment planning	$0
D9610	Therapeutic parenteral drug, single administration	$10
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$15
D9630	Other drugs and/or medicaments, by report	$15
D9910	Application of desensitizing medicament	$15
D9940	Occlusal guard, by report	$45
D9942	Repair and/or reline occlusal guard	$7
D9951	Occlusal adjustment - limited	$20
D9952	Occlusal adjustment - complete	$95
D9971	Odontoplasty, 1-2 teeth; includes removal of enamel projections	$18
D9972	External bleaching - per arch - performed in office	$165
D9975	External bleaching for home application, per arch; includes materials and fabrication of custom trays	$99

D9986	Missed appointment	$25
D9987	Cancelled appointment	$25

** The Policy provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.

B425.0189

B425.0139

BENEFIT LIMITATIONS

This section lists the dental benefits and procedures Members are allowed to obtain through the Policy when the procedures are necessary for their dental health, consistent with professionally recognized standards of practice, subject to the Benefit Limitations, Additional Conditions and Exclusions listed below.

NOTICE: Any benefit that includes an age restricted limitation will be subject to an exception based on medical necessity.

B425.1017

General

- Emergency Dental Services when more than fifty (50) miles from the PCD office: Limited to a $50.00 reimbursement per incident.
- Emergency Dental Services when provided by a Dentist other than the Member's assigned PCD, and without referral by the PCD or authorization by Us: Limited to the benefit for palliative treatment (D9110) only.

B425.0142

Diagnostic

- Office visit Patient Charges that are the Member's responsibility after the group Policy has been in effect for three full years, will be paid to the PCD by Us.
- One intraoral complete series of radiographic images and one panoramic radiographic image: Limited to 1 each in 36 months.
- Bitewing radiographic images: Limited to 2 sets in 12 months.
- 2D oral/facial photographic image: Limited to 1 in 12 months.
- Caries susceptibility tests: Limited to 1 in 24 months.
- Adjunctive pre-diagnostic test that aids in the detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures: Limited to 1 in 24 months for persons age 40 or older.
- Accession of tissue is covered only when performed in conjunction with a tooth-related biopsy, when performed by a Contracted Dentist.

B425.0144

Preventive

- Prophylaxis (D1110 or D1120) or periodontal maintenance (D4910): Limited to 2 in 12 months. One of the covered periodontal maintenance may be performed by a periodontist Contracted Specialist if done within 3 to 6 months following completion of approved periodontal scaling and root planing or osseous surgery by a periodontist Contracted Specialist. Members are eligible to receive 2 additional prophylaxes or periodontal maintenance in the same 12 months at the Patient Charge of D1999 (for prophylaxes) or D4999 (for periodontal maintenance).

One additional prophylaxis will be covered at no charge for Members in any 12 month period who: (a) are pregnant in their 2nd or 3rd trimester; or (b) have clinically demonstrable xerostomia (dry mouth) due to chemotherapy or radiation therapy for the treatment of cancer; or (c) are on dialysis. Verification of the condition must be provided by the Member with a doctor's note to the PCD.

- Fluoride treatment: Limited to 2 in 12 months. Members are eligible to receive 2 additional fluoride treatments in the same 12 months at the Patient Charge of D2999.
- Sealants or preventive resin restoration: Limited to permanent teeth that are free from occlusal restorations, up to age 16, once per tooth in 36 months.
- Sealant Repair: Limited to 1 per tooth in 12 months.

B425.0147

Crowns & Fixed Partial Dentures (Bridges)

- Crowns, fixed partial dentures (bridges), inlays, onlays & veneers: Covered when recommended by the PCD. The replacement of a crown, fixed partial denture (bridge), inlay, onlay or veneer is limited to once in 5 years based on the original placement date while covered under the Policy.
- Multiple crown and fixed partial denture (bridge) unit treatment plan: When a Member's treatment plan includes 6 or more covered units of crown and/or fixed partial denture (bridge) to restore teeth or replace missing teeth, the Member will be responsible for the Patient Charge for each unit of crown or fixed partial denture (bridge), plus an additional charge per unit (D6999), as shown in the Covered Dental Procedures and Patient Charges section.
- Porcelain crowns and/or porcelain fused to metal crowns: Covered on all permanent adult teeth when recommended by the PCD.
- The Policy provides for the use of noble metal for crowns, fixed partial dentures (bridges), inlays and onlays. When high noble metal (including gold) is used, the Member will be responsible for the listed Patient Charge for the crowns, fixed partial dentures (bridges), inlays and onlays, plus an additional charge for the actual cost of the high noble metal.
- In the event a covered indirect restoration (inlays, onlays, crowns and fixed partial dentures - bridges) is recommended and the Member elects to have a porcelain/ceramic substrate indirect restoration made using a CAD/CAM machine in one appointment, in lieu of a laboratory processed porcelain/ceramic substrate indirect restoration (more than one appointment), the Member will be responsible for a fee of $500 in addition to the listed Patient Charge for such porcelain/ceramic substrate indirect restoration. Please note that the one-appointment porcelain/ceramic substrate indirect restoration may not be available at all Contracted General Dentist locations.

B425.0148

Endodontics

- Root amputation, per root: Limited to once per tooth.

- Hemisection: Limited to once per tooth.

B425.0149

Periodontics

- Gingival flap procedure or osseous surgery: Limited to 1 procedure per quadrant in 36 months.
- Tissue grafts: Limited to 1 procedure per tooth/site in 36 months.
- Periodontal scaling and root planing: Limited to once per quadrant in 12 months.
- Bone replacement grafts: Limited to once per site in 10 years when the tooth is present.
- Guided tissue regeneration: Limited to once per site in 10 years when the tooth is present.

B425.0151

Prosthodontics

- Reline and rebase of a complete or partial denture: Limited to once per denture in 12 months.
- The benefit for dentures includes all post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures includes follow-up care for 6 months but does not include rebasing or relining procedures or a complete new denture.
- Replacement of dentures: Covered when recommended by the PCD and only if the existing denture cannot be made satisfactory by reline, rebase or repair. The replacement of a denture is limited to once in 5 years based on the original placement date while covered under the Policy.
- Immediate dentures are not subject to the 5-year replacement limitation.

B425.0152

Oral and Maxillofacial Surgery

- Routine post-operative office visits and care: Included in the surgical procedure.

B425.0154

Orthodontics

- The Policy covers orthodontic procedures as listed under Covered Dental Procedures and Patient Charges. Coverage is limited to one course of comprehensive treatment per Member. Treatment must be preauthorized and be performed by an orthodontist Contracted Specialist.
- The listed Patient Charge for each phase of orthodontic treatment (limited, interceptive or comprehensive) covers up to 24 months of active treatment. If treatment is necessary beyond 24 months, the Member will be responsible for each additional month of treatment, based upon the orthodontist Contracted Specialist's contract.
- Orthodontic procedures are not covered if comprehensive treatment begins before the Member is eligible for benefits under the Policy except as described under the Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.

- If a Member's coverage terminates after the fixed banding appliances are inserted, the Member is responsible for any additional charges incurred for the remaining orthodontic treatment. The orthodontist Contracted Specialist may prorate his or her usual fee over the remaining months of treatment. The Member is responsible for all payments to the orthodontist Contracted Specialist for procedures after the termination date.
- Retention procedures are covered at the Patient Charge shown in the Covered Dental Procedures and Patient Charges section. They are covered only if following a course of comprehensive orthodontic treatment started and completed under the Policy.
- If a Member transfers to another orthodontist Contracted Specialist after authorized comprehensive orthodontic treatment has started under the Policy, the Member will be responsible for any additional costs associated with the change in orthodontist Contracted Specialist and subsequent treatment.
- The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the Member's responsibility.
- The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention procedures are covered only following a course of comprehensive orthodontic treatment covered under the Policy.
- The Policy does not cover any incremental charges for non-standard orthodontic appliances or those made with clear, ceramic, white or other optional material or lingual brackets. Any additional costs for the use of optional materials will be the Member's responsibility.
- If a Member has orthodontic treatment associated with orthognathic surgery (a non-covered procedure involving the surgical moving of teeth), the Policy provides the standard orthodontic benefit. The Member will be responsible for additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the orthodontist Contracted Specialist's usual fee.

B425.0407

Adjunctive General Services

- Deep sedation/general anesthesia, IV sedation, nitrous oxide, non-intravenous conscious sedation: Limited to procedures provided by an oral surgeon Contracted Specialist. Not all oral surgeon Contracted Specialists offer these procedures. The Member is responsible for identifying and receiving procedures from an oral surgeon Contracted Specialist who is willing to provide deep sedation/general anesthesia, IV sedation, nitrous oxide or non-intravenous conscious sedation. The Member's Patient Charge is shown in the Covered Dental Procedures and Patient Charges section.
- Occlusal guard: Limited to 1 in 5 years. Covered only if performed by the PCD.

- Repair and/or reline of occlusal guard: Limited to 1 in 24 months if performed more than 24 months after initial fabrication and delivery.
- Occlusal adjustment - limited: Limited to a total of 2 visits, per lifetime.

B425.0156

ADDITIONAL CONDITIONS

B425.0157

Alternative Procedure Policy

There may be a number of accepted methods of treating a specific dental condition. In all cases where there is more than one course of treatment (procedure) available, a full disclosure of all the treatment options must be given to the Member before treatment is initiated. This PCD-presented document should include a written treatment plan, as well as the cost of each treatment option, in order to minimize the potential for confusion over what the Member should pay, and to fully document the informed consent of the treatment recommended.

When a Member selects an Alternative Procedure over the procedure recommended by the PCD, the Member must pay the difference between the PCD's usual charges for the recommended procedure and the Alternative Procedure chosen by the Member. The Member will also have to pay the applicable Patient Charge for the recommended procedure.

If any of the Alternative Procedures that are selected by the Member are not covered under the Policy, the Member must pay the PCD's usual fee for the Alternative Procedure.

If any treatment is specifically not recommended by the PCD (i.e., the PCD determines it is not an appropriate procedure for the condition being treated), the PCD is not obliged to provide that treatment even if it is a covered procedure under the Policy.

Members can request and receive a second opinion by contacting Our Member Services department in the event they have questions regarding the recommendations of the PCD or Contracted Specialist.

B425.0158

Exceptions to Alternative Procedure Policy

When the Member selects a posterior composite restoration as an Alternative Procedure to a recommended amalgam restoration, the Alternative Procedure policy does not apply.

When the Member selects an extraction, the Alternative Procedure policy does not apply.

When the PCD recommends a crown, the Alternative Procedure policy does not apply regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The Member must pay the applicable Patient Charge for the crown actually placed.

B425.0159

Second Opinion Consultation

A Member may wish to consult another Dentist for a second opinion regarding procedures recommended or performed by the Member's PCD or Contracted Specialist through a referral. To have a second opinion consultation covered by Us, the Member must call or write Our Member Services department for prior authorization. We only cover a second opinion consultation when the recommended procedures are covered under the Policy.

A Member Services associate will help identify a Contracted Specialist to perform the second opinion consultation. The second opinion consultation will include the applicable Patient Charge for code D9310.

The Plan's benefit for a second opinion consultation is limited to $50.00. If a Contracted Specialist is the consulting Dentist, the Member is responsible for the applicable Patient Charge for code D9310. If a Non-Contracted Dentist is the consulting Dentist, the Member must pay the applicable Patient Charge for code D9310 and any portion of the Dentist's fee over $50.00.

The Member Services associate will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting Dentist.

B425.0727

Third Opinion Consultation

Third opinions are not covered unless requested by Us. If a third opinion is requested by the Member, the Member is responsible for the payment. Exceptions will be considered on an individual basis, and must be approved, in writing, by Us.

B425.0161

Treatment in Progress-Takeover Benefit for Orthodontic Treatment Provision

This provision provides a Member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another Dental HMO plan with the current/original treating orthodontist, after the Policy becomes effective. A Member may be eligible for this provision if all of these conditions are met:

- The Member was covered by another dental HMO plan just prior to the Effective Date of the Policy and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with the current/original treating orthodontist under the prior Dental Policy. This benefit applies to Members who are eligible for coverage on the Effective Date of the Policy and enroll for such coverage within 30 days. It does not apply to persons who become newly eligible for coverage after the Effective Date of the Policy.
- The Member has such orthodontic treatment in progress at the time the Policy becomes effective.
- The Member continues such orthodontic treatment with the current/original treating orthodontist.
- A "Treatment in Progress - Takeover Benefit for Orthodontic Treatment" form, completed in its entirety by the treating orthodontist, is submitted to Us within 6 months of the Effective Date of the Policy.

The benefit amount will be calculated based on the prior dental HMO carrier's pro-rated remaining benefit balance; up to a maximum benefit of $1,200 per Member. The Member is responsible for the Dentist's original comprehensive treatment fee and Patient Charges under the original contract and financial agreement made between the Member and the Dentist. The Member is responsible for any increase in fee as a result of the takeover process. Additionally, the Plan will only cover up to a total of 24 months of comprehensive orthodontic treatment.

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EXCLUSIONS

We will not pay benefits for:

- Treatment needed due to an on-the-job or job-related injury or a condition for which benefits are payable by Worker's Compensation, occupational disease law or similar laws, whether or not the Member claims his or her rights to such benefits.
- Any treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered procedure involving (a) congenitally missing or (b) supernumerary teeth.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatments or appliances requested, recommended or performed: (a) which in the opinion of the Contracted Specialist or Contracted General Dentist are not necessary for maintaining or improving the Member's dental health, or (b) which are solely for cosmetic purposes, except for bleaching.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or is considered by the American Dental Association (ADA) to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis, or the fabrication of a spare appliance or prosthesis.
- Replacement or repair of prosthetic appliances damaged due to the neglect of the Member.
- Any Member request for specialist procedures or treatment which can be routinely provided by the PCD, or by a specialist without a direct referral from the PCD or a pre-authorization by Us.
- Treatment provided by any public program, or paid for or sponsored by any government body, unless We are legally required to provide benefits for such treatment.
- Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion; (3) treat a condition necessitated by attrition or abrasion; (4) splint or stabilize teeth for periodontal reasons; or (5) improve cosmetic appearance, except for bleaching.
- Any procedure, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).
- Dental procedures, other than covered Emergency Dental Services, which were performed by any Dentist other than the Member's selected and assigned PCD, unless previous written authorization was provided by Us.

- 2D cephalometric radiographic images except when performed as part of an orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Treatment which requires the procedures of a prosthodontist.
- Treatment or Procedures which requires the services of a pediatric dentist Contracted Specialist, after the Member's 9th (ninth) birthday.
- Consultations for non-covered procedures.
- Any procedure or treatment not specifically listed in the Covered Dental Procedures and Patient Charges section.
- Any covered procedure, regardless of specialty, that was started, but not completed, prior to the Member's eligibility to receive benefits under the Policy except as described under Treatment in Progress - Takeover Benefit for Orthodontic Treatment Provision.
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered procedures, including, but not limited to, root canal therapy to facilitate overdentures.
- Procedures, appliances or devices to guide minor tooth movement, except as covered under limited, interceptive or comprehensive orthodontic treatment or correct or control harmful habits.
- Any procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances lost or damaged.
- Accident injury. An accident injury is defined as damage to the hard and/or soft tissue of the oral cavity resulting from forces external to the mouth. Damages to the hard and soft tissues of the oral cavity from normal masticatory (chewing) functions will be covered at the amount as shown in the Covered Dental Procedures and Patient Charges section.

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COMBINED EVIDENCE OF COVERAGE AMENDMENT

This Rider amends the Combined Evidence of Coverage as follows and is effective on 07/01/2017.

Timely Access to Care

Covered dental services must be provided in a timely manner appropriate with the nature of Your condition consistent with good professional dental practice.

Managed Dental Care's network has adequate capacity and availability of Contracted Dentists to offer appointments for covered dental services in accordance with the following Timely Access to Care requirements:

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

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

When it is necessary for Your Dentist or You to reschedule an appointment, the appointment will be promptly rescheduled by Your Dentist in a manner that is:

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

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

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

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

If You have any questions or want to request an interpreter, please call Managed Dental Care's Customer Response Unit at 1-800-273-3330.

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

Managed Dental Care of California

Larry Weiss, Assistant Vice President and Controller

Jill M. Purcell, President

B425.0840

MATRIX

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

PLAN N300M	**Deductibles**	**Lifetime Maximums**	**Professional Services**			
			Diagnostic	Preventive	Restorative	Endodontic
	None					
Services			Oral Evaluations; X-Rays: Intraoral Bitewings Panorex; Miscellaneous: Primary Care Diagnostic Services	Prophylaxis (Cleaning); Flouride; Sealants; Space Maintainers	Amalgam & Resin: Restorations (Fillings); Crowns And Pontics; Inlay And Onlay Miscellaneous: Restorative Services	Pulp Cap; Pulpotomy; Root Canals; Retreatments; Apicoectomy; Retrograde Filling
Patient Charge Range			Oral Evaluations; Radiographic Images (X-Rays) Intraoral Panorex - $0; Miscellaneous Primary Care Diagnostic Services - $0	Prophylaxis - $0 - $35; Flouride - $0 - $20; Sealants - $8 - $35; Space Maintainers - $65 - $85	Amalgam - $8 - $17; Resin - $20 - $60; Crowns - $225 - $425; Inlays & Onlays - $250 - $420; Labial Veneer - $235 - $350; Miscellaneous Restorative Services - $0 - $140	Pulp Cap -$12; Pulpotomy - $35; Root Canals - $120 - $180; Retreatments - $325 - $380; Apicoectomy - First Root - $240 - $335; Apicoectomy - Each Additional Root - $95; Retrograde Filling - Per Root - $73; Canal Preparation - $20

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N300M	**Deductibles**	**Lifetime Maximums**	**Professional Services (Continued)**			
			Diagnostic	Preventive	Restorative	Endodontic
Limitations		One Course Of Comprehensive Orthodontic Treatment Per Member	Full Mouth X-Rays - 1 Set Per 3 Year Period; Bite Wing X-Rays - 2 Sets In Any 12 Month Period; Panoramic - One In Any 3 Year Period Adjunctive Pre-Diagnostic Test In Detection Of Abnormalities One In Any 2-Year Period After 40th Birthday	Routine Cleaning (Prophylaxis) or Periodontal Maintenance Procedure - Total Of 4 Services In Any 12-Month Period Fluoride Treatment Sealants - Limited To Permanent Teeth, Up To 16th Birthday, One Per Tooth In Any 3-Year Period	Crown Replacement - Once Per 5 Years; Actual Cost Of Gold/High Noble Metal Is Member's Responsibility	

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THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N300M	**Professional Services**					
	Periodontic	Prosthodontics	Implants	Oral Surgery	Orthodontic	Adjunctive General Services
Services	Gingivectomy/ Gingivoplasty; Gingival Flap Procedure; Osseous Surgery; Scaling & Root Planing; Soft Tissue Graft; Miscellaneous Periodontal Services	Complete Dentures; Partial Dentures; Relines; Repairs; Denture Adjustments	Abutment Supported Crowns; Implant Supported Dentures, Abutment Supported Retainers; Bone Graft, Re-Cement/ Rebond Implant	Extractions; Biopsy; Alveoplasty; Incision And Drainage; Frenectomy/ Frenulectomy; Removal Of Cyst/Tumor	Comprehensive Treatment; Retention; Pre-Orthodontic Treatment; Treatment Plan And Records	Office Visit; Palliative Treatment; Local Anesthesia
Patient Charge Range	Gingivectomy/ Gingivoplasty - $40 - $125**; Gingival Flap Procedure - $140 - $240; Osseous Surgery - $230 - $380**; Scaling & Root Planing - $30 - $50; Soft Tissue Graft - $175 - $270; **Per-Quadrant	Prosthodontics Removable Complete Denture - $452; Partial Denture - $160 - $575; Reline - $88 - $120; Repair - $36 - $85; Denture Adjustment - $23 Prosthodontics Fixed Pontic - $135 - $425 Inlay and Onlay - $320 - $400 Crown - $225 - $425	Abutment Supported Crowns - Not Covered; Covered Implant Supported Dentures - Not Covered; Abutment Supported Retainers - Not Covered; Bone Graft - Not Covered; Re-Cement/ Rebond Implant - Not Covered;	Simple Extractions - Removal Of Complete Bony Impactions - $110 - $140; Biopsy, Oral Tissue - $70 - $95 Alveoloplasty - $40 - $85; Incision - And Drainage - $35 - $70; Frenectomy/ Frenulectomy - $115 - $170 Removal of Cyst/Tumor - $180 - $235;	Under age 19 - $1,895; Age 19 and Above - $2,195; Retention - $400; Treatment Plan And Records - $250	Office Visit - $5; After Hours Office Visit - $50; Palliative Treatment - $20; Local Anesthesia - $0;

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THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N300M	**Professional Services**					
	Periodontic	Prosthodontics	Implants	Oral Surgery	Orthodontic	Adjunctive General Services
Limita-tions	Gingival Flap/ Osseous Surgery - One Service Per Quadrant Or Area In Any 3 Year Period; Soft Tissue Graft - One Service Per Area In Any 3 Year Period; Scaling And Root Planing - One Per Quadrant In Any 12 Month Period	Actual Cost Of Gold/High Noble Metal Is Member's Responsibility; Reline Of Denture - One Per Denture In Any 12 Month Period; Rebase Of Denture - One Per Denture In Any 12 Month Period	Implants - Limited To 2 Per 12 Months. Replacement Of An Implant/ Abutment Is Not covered Within 10 Years Of The Original Placement Date	Impacted Teeth - Radiographic Evidence Of A Pathology; Limited To Non-Orthodontic Extractions; Biopsy - Tooth Related Only; Removal Of Cyst/Tumor - Tooth Related Only	One Course of Comprehensive Treatment Per Member; 24 Months Of Active Treatment; Limited To Fixed Banding Appliances Only; Limited To Initial Comprehensive Treatment Only	

THIS IS A REVISED UNIFORM MATIRX WHICH SUPERSEDES ANY OTHER UNIFORM MATRIX INCLUDED IN THE EVIDENCE OF COVERAGE/DISCLOSURE FORM.

REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

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THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS. (CONTINUED)

N300M	Outpatient Services	Hospitalization Service	Emergency Health Coverage		Ambulance Services	Prescription Drug Services
			In-Area Emergency Dental Service	Out-Of-Area Emergency Dental Service		
	Not Covered*	Not Covered*	MDC Network Provides For Emergency Dental Services 24 Hours Per Day, 7 Days Per Week	Emergency Dental Service When More Than 50 Miles From Primary Care Dentist's Office: Limited to $50 Reimbursement Per Incident	Not Covered*	Not Covered*

N300M	Durable Medical Equipment	Mental Health Services	Chemical Dependency Services	Home Health Services	Other
	Not Covered*	Not Covered*	Not Covered*	Not Covered*	Not Covered*

***SERVICES LISTED AS "NOT COVERED" ARE GENERALLY INAPPLICABLE TO DENTAL COVERAGE.**

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REGULATIONS REQUIRE THE PLAN TO PROVIDE A UNIFORM HEALTH PLAN BENEFITS AND COVERAGE MATRIX.

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