



**GUARDIAN<sup>SM</sup>**

**YOUR GROUP INSURANCE  
PLAN BENEFITS**

**G&A PARTNERS  
CLASS 0027 0028  
DENTAL, VISION**

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

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**CERTIFICATE OF COVERAGE**

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**The Guardian**

*7 Hanover Square  
New York, New York 10004*

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

*Stuart J Shaw*  
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3

B110.0023



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## **SECTION I: Non-Managed DentalGuard Insurance**

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**This part of your booklet does not apply to your plan of Managed DentalGuard dental care expense insurance.**

**Your Managed DentalGuard dental care expense insurance plan appears later in this booklet.**

B850.0181





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## IMPORTANT NOTICE

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- 1) To obtain information or make a complaint:
- 2) You may call The Guardian's toll-free telephone number for information or to make a complaint at:

1-800-459-9401

- 3) You may also write to The Guardian at:

The Guardian Life Insurance  
Company of America  
East 777 Magnesium Road  
Spokane, Washington 99208-5884

- 4) You may contact the Texas Department of Insurance on companies, coverages, rights, or complaints at:

1-800-252-3439

- 5) You may write the Texas  
Department of Insurance  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

- 6) **PREMIUM OR CLAIM DISPUTES:** Should you have a dispute concerning your premium or about a claim, you should contact The Guardian Life Insurance Company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

- 7) **ATTACH THIS NOTICE TO YOUR POLICY:**  
This notice is for information only and does not become a part or condition of the attached document.

CGP-3-R-DISC-TX-92

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## AVISO IMPORTANTE

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Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de The Guardian's para informacion o para someter una queja al:

1-800-459-9401

Usted tambien puede escribir a The Guardian:

The Guardian Life Insurance  
Company of America  
East 777 Magnesium Road  
Spokane, Washington 99208-5884

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de  
Seguros de Texas  
P.O. Box 149104  
Austin, TX 78714-9104  
FAX # (512) 475-1771  
Web: <http://www.tdi.state.tx.us>  
E-mail: [ConsumerProtection@tdi.state.tx.us](mailto:ConsumerProtection@tdi.state.tx.us)

**DISPUTAS SOBRE PRIMAS O RECLAMOS:** Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con el The Guardian Life Insurance Company primero. Si no se resuelve la disputa, puedo entonces comunicarse con el departamento (TDI).

**UNA ESTE AVISO A SU POLIZA:** Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

B120.0068



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## IMPORTANT NOTICE

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The insurance policy under which this certificate is issued is not a policy of Workers' Compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the Workers' Compensation system.

CGP-3-R-COMP-TX-92

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**IMPORTANT NOTICE FOR EMPLOYEES OF AN ARIZONA WORK LOCATION**

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For employees who work at your employer's Arizona location, your certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read your certificate carefully.

B120.0082



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## GENERAL PROVISIONS

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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

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## 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

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## Incontestability

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

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

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

CGP-3-R-INCY-90

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## 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

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## 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 within 60 days after 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.



## Accident and Health Claims Provisions (Cont.)

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**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-TX

B160.0033

## **Coordination Between Continuation Sections**

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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**

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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

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## YOUR CONTINUATION RIGHTS

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### Federal Continuation Rights

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**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.

## Federal Continuation Rights (Cont.)

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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

B235.0622

**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.

## Federal Continuation Rights (Cont.)

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### **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.

## Federal Continuation Rights (Cont.)

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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;

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## Federal Continuation Rights (Cont.)

- (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

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## 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

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## YOUR CONTINUATION RIGHTS

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### Important Notice

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This section does not apply to coverages 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."

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### Continuation of Coverage During a Labor Dispute

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**If A Work Stoppage Occurs** A labor dispute may result in a work stoppage which causes your group coverage to end. If this happens, you have the right to continue your group coverage for yourself during the work stoppage, for up to 6 months.

**How To Continue Group Coverage** To continue your group coverage you must make timely payment of the total premium, including any portion of the premium your employer was paying before work stopped, to the union representing you. If you fail to pay a premium on time, you waive your right to continue under this section.

**The Responsibilities of the Union** For your group coverage to continue, the union representing you must do the following:

- (a) collect the premium payments made by you; and
- (b) make timely payment of the collected premiums to us.

If any such union, after timely receipt of your premium, fails to pay us on your behalf, thereby causing your group coverage to end, then such union will be liable to you for your benefits, to the same extent as, in place of, us.

**The Premium** The premium you must pay for continued group coverage will be at the rate that applies to the class of employees to which you belonged on the day work stopped. But, we have the right to increase this rate by up to 20% of 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** Your continued coverage ends on the first of the following:

- (a) the end of the 6 month continuation period;
- (b) when you enter full-time employment with another employer;
- (c) the day the work stoppage ends;

## **Continuation of Coverage During a Labor Dispute (Cont.)**

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- (d) at the end of the period for which the last premium payment is made, if you stop paying premium;
- (e) the date you stop being eligible as defined in the group plan, for reasons other than not meeting "actively at work" or "full-time" requirements.

CGP-3-R-CC-LD-1

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## ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

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B505.0152

**When Your Coverage Starts** Your coverage under this *plan* is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But you must be actively at work on a *full-time* basis on that date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on that date, we will postpone your coverage until the date you return to active *full-time* work.

Sometimes, the effective date shown on the sticker is not a regularly scheduled work day. But your coverage will still start on that date if you were actively at work on your last regularly scheduled work day.

CGP-3-EC-90-2.0

B505.0075

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B505.0083

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

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

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

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

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### **When Continuation Ends**

Coverage may continue until the earliest of the following:

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

### **Definitions**

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.
- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means the nearest blood relative of the *employee*.

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

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- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

CGP-3-EC-90-3.0

B449.0727

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## Dependent Vision Care Expense Coverage

CGP-3-DEP-90-1.0

B505.0099

### **Eligible Dependents For Dependent Vision Care Benefits**

Your *eligible dependents* are: (a) your legal spouse; (b) your unmarried dependent children who are under age 25; and (c) your unmarried dependent children from age 25 until their 26th birthday, who are enrolled as full-time students at accredited schools.

An unmarried dependent child who is not able to remain enrolled as a full-time student due to a *medically necessary* leave of absence may continue to be an *eligible dependent* until the earlier of: (a) the date that is one year after the first day of the *medically necessary* leave of absence; or (b) the date on which coverage would otherwise end under this *plan*. You must provide written certification by a treating physician which states that the child is suffering from a serious illness or injury and that the leave of absence is *medically necessary*.

CGP-3-DEP-90-2.0

B505.0792

### **Adopted Children, Step-Children and Grandchildren**

An *employee's* "unmarried dependent children" include: (a) his or her legally adopted children; (b) his or her grandchildren who are dependents for federal income tax purposes at the time application for coverage of the grandchildren are made; and (c) if they depend on him or her for most of their support and maintenance, his or her step-children.

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

### **Dependents Not Eligible**

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

CGP-3-DEP-90-3.0

B505.0222

### **Handicapped Children**

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

## Dependent Vision Care Expense Coverage (Cont.)

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B505.0119

### **When Dependent Coverage Starts**

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

If you do this on or before your *eligibility date*, date, your dependent coverage is scheduled to start on the later of the date you sign the enrollment form and the date you become covered for employee coverage.

If you do this within 31 days of your *eligibility date*, date, your dependent coverage is scheduled to start on the date you become covered for employee coverage.

If you do this after the enrollment *period* ends, you can't enroll your initial *dependents* until the next vision open enrollment period.

Once you have coverage for your initial *dependents*, you must notify us when you acquire any new dependents, and agree to make any additional payments required for the coverage. If you do this within 31 days of the date the newly *acquired dependent* becomes eligible, the dependent's coverage will start on the date the dependent becomes eligible. If you fail to notify us on time, you can't enroll the newly *acquired dependent* until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can't be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can't be enrolled again until the next vision open enrollment period.

CGP-3-DEP-90-6.0

B505.0714

### **Exception**

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

CGP-3-DEP-90-7.0

B505.0132

## Dependent Vision Care Expense Coverage (Cont.)

**Newborn Children** We cover your newborn child from the moment of birth if you're already insured for dependent vision coverage, and you notify us within 31 days of the child's birth. If you fail to notify us on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is your first *eligible dependent*, we cover the child from the moment of birth if you enroll for dependent coverage and agree to make any required payments within 31 days of the child's birth. If you fail to enroll on time, you can't enroll the child until the next vision open enrollment period.

If the newborn child is not your first *eligible dependent*, but you did not previously enroll your other *eligible dependents* for vision care expense coverage, you can enroll the child during the next vision open enrollment period, if you also enroll all of your other *eligible dependents* at this time.

CGP-3-DEP-90-8.0

B505.0153

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

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

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

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

An individual dependent's coverage ends when he stops being an *eligible dependent*. This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the *employee* for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment.

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

CGP-3-DEP-90-9.0

B505.0139

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## CERTIFICATE AMENDMENT

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This rider amends the "Dependent Coverage" provision as follows:

An employee's domestic partner will be eligible for vision care coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

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

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.



## Certificate Amendment (Cont.)

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

But, at the end of such coverage, continuation and conversion rights, if any, to which the domestic partner and his or her dependent children may be entitled, will be available. Read "Continuation Rights" and "Converting This Group Health Insurance" to find out what is allowed under this plan and how it works. The domestic partner and his or her children will be not eligible for survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section.

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

Stuart J Shaw  
Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DMST-96-WI

B505.0171

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**VISION CARE HIGHLIGHTS**

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

<b>PPO Copayments</b>	Examinations . . . . .	\$20.00
	Standard Frames and/or Standard Lenses . . . . .	\$20.00
	Necessary Contact Lenses . . . . .	\$20.00
<b>Non-PPO Cash Deductibles</b>	Examinations . . . . .	\$20.00
	Standard Frames and/or Standard Lenses . . . . .	\$20.00
	Necessary Contact Lenses . . . . .	\$20.00
<b>Payment Rates</b>	For Covered Charges . . . . .	100%

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## VISION CARE EXPENSE INSURANCE

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This insurance will pay many of your and your covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

CGP-3-VSN-96-VIS

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### Vision Service Plan - This Plan's Vision Care Preferred Provider Organization

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**Vision Service Plan** This *Plan* is designed to provide high quality vision care while controlling the cost of such care. To do this, the *plan* encourages a *Covered Person* to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care Preferred Provider Organization (PPO).

This vision care PPO is made up of *Preferred Providers* in a *Covered Person's* geographic area. A vision care *Preferred Provider* is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP and (b) has a participatory agreement in force with VSP.

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

When an *employee* and his or her dependents enroll in this *Plan*, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care *Preferred Providers*.

What we pay is based on all the terms of this *Plan*. The *Covered Person* should read this material with care and have it available when seeking vision care. Read this *Plan* carefully for specific benefit levels, *Copayments*, *Deductibles*, payment rates and payment limits.

The *Covered Person* can call VSP if he or she has any questions after reading this material.

**Choice of Preferred Providers** When a person becomes enrolled in this *Plan*, and annually thereafter, he or she will receive a list of VSP *Preferred Providers* in his or her area. A *Covered Person* may receive vision services from any VSP *Preferred Provider*.

**Replacement of Preferred Provider** If a *Preferred Provider* terminates his or her relationship with VSP for any reason, VSP shall be responsible for furnishing vision services to *Covered Persons* either through that provider or through another VSP *Preferred Provider*.

**Vision Service Plan**

**This Plan's Vision Care Preferred Provider Organization (Cont.)**

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**Pre-Authorization of Preferred Provider Services** When a *Covered Person* desires to receive treatment from a *Preferred Provider*, the *Covered Person* must contact the *Preferred Provider* BEFORE receiving treatment. The *Preferred Provider* will contact VSP to verify the *Covered Person's* eligibility and VSP will notify the *Preferred Provider* of the 60 day time period during which the *Covered Person* may schedule an appointment. If the *Covered Person* cancels an appointment and reschedules it, it must be done within those 60 days. If the appointment is not rescheduled during the previously approved time period, the *Covered Person* must contact the *Preferred Provider* again to receive authorization.

What we pay is subject to all of the terms of this *Plan*.

CGP-3-VSN-96-PPOATX

B505.0393

**Pre-Treatment Review for Necessary Contact Lenses** Subject to prior approval by VSP consultants, we will pay benefits for Necessary Contact Lenses provided to a *Covered Person*. A *Covered Person's* doctor will request approval for Necessary Contact Lenses from VSP.

If Contact Lenses are not found to be medically necessary, and a *Covered Person* receives Contact Lenses under this Policy, they will be treated as Elective Contact Lenses and the provisions of the Elective Contact Lenses section of this Policy will not apply.

What we pay for Necessary Contact Lenses is subject to all of the terms of this *Plan*.

CGP-3-VSN-96-PTR2TX

B505.0395

**Claim Appeals And Arbitration Of Disputes** If, under the provisions of this *plan*, a claim for benefits is denied in whole or in part, a request, in writing, may be submitted to VSP for a full review of the denial.

The written request must be made to the Plan Administrator within 60 days following the denial of benefits. The request should contain sufficient information to identify the *covered person* whose benefits were denied. This includes the name of the *covered person*, the *employee's* social security number and the *employee's* date of birth. The *covered person* may state the reasons he or she believes that the denial of the claim was in error and may provide any pertinent documents which he or she wishes to be reviewed. The Plan Administrator will review the claim and give the *covered person* the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of the Plan Administrator, including specific reasons for the decision, shall be provided and communicated to the *covered person* in writing within one hundred twenty (120) days after receipt of a request to review.

Any dispute or question arising between VSP and any *covered person* involving the application, interpretation or performance under this *plan* shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation. If any issue cannot be resolved in this fashion, it may be submitted to arbitration, if both parties agree.

## Vision Service Plan

### This Plan's Vision Care Preferred Provider Organization (Cont.)

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The procedure for arbitration shall be conducted pursuant to the rules of the American Arbitration Association.

**Preferred Provider  
Grievance  
Procedures** Grievances are handled by VSP's Professional Relations Vice President for action. The grievance process is designed to address *covered persons'* concerns quickly and satisfactorily. The following grievance procedures have been established:

- (1) The patient's written complaint will be referred to VSP's Professional Relations Vice President for action.
- (2) The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.
- (3) If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the *covered person*. Otherwise, a notice of receipt of the complaint will be forwarded to the *covered person* advising the time for resolution.
- (4) Grievance procedures and complaint forms will be maintained in each *preferred provider's* office.
- (5) All complaints will be retained in the Professional Relations Department.

Complaints and grievances may be sent to the Professional Relations Vice President at:

**Vision Service Plan, Inc.**  
3333 Quality Drive  
Rancho Cordova, California 95670  
(877) 814-8970 or (800) 877-7195

CGP-3-VSN-96-APP

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## How This Plan Works

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

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## Services or Supplies from a Preferred Provider

If a *Covered Person* uses the services of a *Preferred Provider*, the *Preferred Provider* will receive approval from VSP prior to providing the *Covered Person* with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this *Plan* for specific requirements.

**Copayments** The *Covered Person* must pay a *Copayment* when he or she receives services from a *Preferred Provider*. We pay benefits for the covered charges a *Covered Person* incurs in excess of the *Copayment*. This *Plan's* *Copayments* are as follows:

## Services or Supplies From a Preferred Provider (Cont.)

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For each vision examination from a *Preferred Provider* . . . . . \$20.00

For each pair of *Standard Frames* and/or  
*Standard Lenses* from a *Preferred Provider* . . . . . \$20.00

For Necessary Contact Lenses from a *Preferred Provider* . . . . . \$20.00

**Payment Limits** Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *Plan*. When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

**Payment Rates** Once a *Covered Person* has paid any applicable *Copayment*, we pay benefits for covered charges under this *Plan* as follows. What we pay is subject to all of the terms of this *Plan*.

For Covered Charges . . . . . 100%

**Discounts** If a *Covered Person* receives a vision examination, and lenses or frames from a *Preferred Provider*, he or she will receive a discount on the cost of purchasing an unlimited number of prescription glasses and non-prescription sunglasses from any *Preferred Provider*. The *Covered Person* may also receive a discount on the costs of evaluation and fitting of contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination.

The discounts are:

For Prescription Glasses . . . . . 20% off of the *preferred provider's*  
*usual and customary fee*

For Non-Prescription Sunglasses . . . . 20% off of the *preferred provider's*  
*usual and customary fee*

For Contact Lens Evaluation and . . . . 15% off of the *preferred provider's*  
Fitting Costs . . . . . *usual and customary fee*

CGP-3-VSN-96-BEN1TX

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## Services or Supplies From a Non-Preferred Provider

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If a *Covered Person* uses the services of a *Non-Preferred Provider*, the *Covered Person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received, or as soon as reasonably possible. The benefits we pay are subject to all of the terms of this *Plan*.

**Cash Deductible for Services of a Non-Preferred Provider** There are separate cash *Deductibles* for each covered service provided by a *Non-Preferred Provider*. These cash *Deductibles* are shown below. The *Covered Person* must have covered charges in excess of the cash *Deductible* before we pay him or her any benefits for the service or supply.

For each vision examination provided by a *Non-Preferred Provider* . . \$20.00

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## Services or Supplies From a Non-Preferred Provider (Cont.)

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For each pair of *Standard Frames* and/or  
*Standard Lenses* from a *Non-Preferred Provider* . . . . . \$20.00

For each pair of Necessary Contact Lenses from  
a *Non-Preferred Provider* . . . . . \$20.00

**Payment Limits** Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this *Plan*. When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

**Payment Rates** Once a *Covered Person* has met any applicable *Deductible*, we pay benefits for Covered Charges under this *Plan* as follows. What we pay is subject to all of the terms of this *Plan*.

For Covered Charges . . . . . 100%

CGP-3-VSN-BEN2TX

B505.0401

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## Covered Charges

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Covered charges are the *usual* and *customary* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges.

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## Covered Services and Supplies

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This section lists the types of charges we cover. But what we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

All covered vision services must be furnished by or under the direct supervision of an optometrist, ophthalmologist or other licensed or qualified vision care provider. The services or supplies must be the *usual* and *customary* treatment for a vision condition.

**Vision Examinations** We cover charges for comprehensive vision care examinations. Such examinations include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. When a vision examination indicates that new lenses or frames or both are *visually necessary and appropriate* for the proper visual health of a *covered person*, professional services covered by this *plan* include:

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

## Covered Services and Supplies (Cont.)

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We don't cover more than one vision examination in any calendar year period.

And if a *covered person* uses a *non-preferred provider*, we limit what we pay for each vision examination to \$39.00.

CGP-3-VSN-96-LIST1

B505.0935

**Standard Lenses** We cover charges for single vision, bifocal, trifocal or *lenticular lenses*. We cover glass, plastic or for dependent children to age 26, polycarbonate lenses.

If a *covered person* uses a *non-preferred provider*, we limit what we pay to

- \$23.00 for each pair of single vision lenses
- \$37.00 for each pair of bifocal lenses
- \$49.00 for each pair of trifocal lenses and
- \$64.00 for each pair of *lenticular lenses*.

CGP-3-VSN-09-SL

B505.0941

We cover charges for one pair of *standard lenses* in any calendar year *benefit period*.

CGP-3-VSN-09-SL

B505.0962

**Standard Frames** We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of \$130.00, plus 20% of any amount over the allowance.

If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to \$46.00.

If the covered person chooses elective contact lenses, we do not cover standard frames until the beginning of the calendar year following the next calendar year after the date the elective contacts are purchased.

We cover charges for one set of standard frames in any period of 2 calendar years.

CGP-3-VSN-15-SF

B505.1553

**Necessary Contact Lenses** We cover charges for Necessary Contact Lenses upon prior approval by VSP. We cover charges, and charges for related professional services, only if the lenses are needed:

- (a) following cataract surgery;
- (b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
- (c) for certain conditions of *anisometropia*; or
- (d) for *keratoconus*.



## Covered Services and Supplies (Cont.)

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We don't cover charges for more than one pair of Necessary Contact Lenses in any calendar year period.

If a *covered person* receives Necessary Contact Lenses from a *preferred provider*, we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a *non-preferred provider*, we limit what we pay to \$210.00 in any calendar year period.

CGP-3-VSN-96-LIST7

B505.0996

### **Elective Contact Lenses**

We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses until the next calendar year and standard frames for a period of 2 calendar years.

If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to \$130.00

If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to \$100.00.

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

CGP-3-VSN-09-ECL

B505.1006

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## Special Limitations

### If This VSP Plan Replaces Another VSP Plan

If, prior to being covered under this *plan*, a *covered person* was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this *plan*, the date he or she received such a covered service will be used as the last date of service when applying the *benefit period* limitations under this *plan*. We apply this provision only if the *covered person* was enrolled in another VSP plan immediately before enrolling in this *plan*.

CGP-3-VSN-96-SL1

B505.0031

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## Exclusions

- We won't pay for *orthoptics* or vision training and any associated supplemental testing.
- We won't pay for medical or surgical treatment of the eyes.
- We won't pay for any eye examination or corrective eyewear required by an employer as a condition of employment.

CGP-3-VSN-96-EXC1

B505.0034

- We will not pay for *plano lenses* (lenses with less than a +/- .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this *plan* which are lost or broken, except at normal intervals when services are otherwise available.
- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.
- We will not pay for a frame that costs more than the plan allowance.
- We will not pay for refitting of contact lenses after the initial 90 day fitting period.
- We will not pay for routine maintenance of contact lenses such as polishing or cleaning.
- We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

CGP-3-VSN-09-EXC

B505.0998

- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

B505.1015

- We will not pay for UV (ultraviolet) protected lenses.

B505.1016

## Exclusions (Cont.)

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- We will not pay for the scratch resistant coating of the lens or lenses.  
B505.1017
  - We will not pay for blended lenses.  
B505.1018
  - We will not pay for high index lenses.  
B505.1019
  - We will not pay for the mirror/ski coating of the lens or lenses.  
B505.1020
  - We will not pay for oversized lenses.  
B505.1021
  - We will not pay for laminating of the lens or lenses.  
B505.1022
  - We will not pay for edge treatment.  
B505.1023
  - We will not pay for progressive lenses.  
B505.1024
  - We will not pay for progressive multifocal lenses.  
B505.1025
  - We will not pay for the anti-reflective coating of the lens or lenses.  
B505.1026
  - We will not pay for polycarbonate lenses.  
B505.1027
- CGP-3-VSN-09-EXC
- Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this *plan's copayments or deductibles*, if any.
- CGP-3-VSN-96-EXC17

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## CERTIFICATE AMENDMENT

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The certificate is amended as follows:

The Vision Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

- (a) your dependent child is a child under age 26;
- (b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);
- (c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and
- (d) reference to an individual dependent's coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

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

**The Guardian** Life Insurance Company of America

Stuart J Shaw  
Vice President, Risk Mgt. & Chief Actuary

CGP-A-1

B531.0101

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## GLOSSARY

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This Glossary defines the italicized terms appearing in your booklet.

CGP-3-GLOSS-90

B900.0118

**Anisometropia** means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.

CGP-3-VSN-96-DEF1

B750.0457

**Benefit Period** with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan*, the covered service is again available to a *covered person*.

CGP-3-VSN-96-DEF3

B750.0458

**Blended Lenses** means bifocals which do not have a visible dividing line.

CGP-3-VSN-96-DEF3

B750.0459

**Coated Lenses** means substance added to a finished lens on one or both surfaces.

CGP-3-VSN-96-DEF3

B750.0460

**Copayment** with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a *covered person* to a *preferred provider* at the time covered vision services are received.

CGP-3-VSN-96-DEF3

B750.0461

**Covered Person** with respect to Vision Care Insurance, means an *employee* or eligible dependent who meets this *plan's* eligibility criteria and who is covered under this *plan*.

CGP-3-VSN-96-DEF3

B750.0462

**Customary** with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn't more than the *usual* charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-VSN-96-DEF3

B750.0484

**Deductible** with respect to Vision Care Insurance, means any amount which a *covered person* must pay before he or she is reimbursed for covered services provided by a *non-preferred provider*.

CGP-3-VSN-96-DEF3

B750.0483

**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

## Glossary (Cont.)

<b>Employee</b>	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	CGP-3-GLOSS-90	B750.0006
<b>Employer</b>	means G&A PARTNERS .	CGP-3-GLOSS-90	B900.0051
<b>Enrollment Period</b>	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
<b>Full-time</b>	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 30 hours per week), at his <i>employer's</i> place of business.	CGP-3-GLOSS-90	B750.0229
<b>Incurred, Or Incurred Date</b>	with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.	CGP-3-VSN-96-DEF3	B750.0466
<b>Initial Dependents</b>	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee</i> coverage. If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0006
<b>Keratoconus</b>	means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.	CGP-3-VSN-96-DEF11	B750.0467
<b>Lenticular Lenses</b>	mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.	CGP-3-VSN-96-DEF11	B750.0485
<b>Newly Acquired Dependent</b>	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	CGP-3-GLOSS-90	B900.0008
<b>Non-Preferred Provider</b>	with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the <i>plan</i> to provide vision care services and/or vision care materials to <i>covered persons</i> of the <i>plan</i> .	CGP-3-VSN-96-DEF14	B750.0487

<b>Orthoptics</b>	means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	
	CGP-3-VSN-96-DEF16	B750.0472
<b>Oversize lenses</b>	mean larger than a <i>standard lens</i> blank, to accommodate prescriptions.	
	CGP-3-VSN-96-DEF17	B750.0489
<b>Photochromic Lenses</b>	mean lenses which change color with the intensity of sunlight.	
	CGP-3-VSN-96-DEF17	B750.0490
<b>Plan</b>	means the <i>Guardian</i> group <i>plan</i> purchased by your <i>employer</i> , 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
<b>Plan Benefits</b>	with respect to Vision Care Insurance, mean the vision care services and vision care materials which a <i>covered person</i> is entitled to receive by virtue of coverage under this <i>plan</i> .	
	CGP-3-VSN-96-DEF17	B750.0492
<b>Plano Lenses</b>	mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).	
	CGP-3-VSN-96-DEF17	B750.0491
<b>Preferred Provider</b>	with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the <i>plan</i> to provide vision care services and/or vision care materials on behalf of <i>covered persons</i> of the <i>plan</i> .	
	CGP-3-VSN-96-DEF14	B750.0488
<b>Standard Frames</b>	mean frames valued up to the limit published by VSP which is given to <i>preferred providers</i> .	
	CGP-3-VSN-96-DEF17	B750.0478
<b>Standard Lenses</b>	mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.	
	CGP-3-VSN-96-DEF17	B750.0479

**Tinted Lenses** mean lenses which have an additional substance added to produce constant tint.

CGP-3-VSN-96-DEF17

B750.0480

**Usual** means, when referring to a covered charge, that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

CGP-3-VSN-96-DEF17

B750.0481

**Visually Necessary  
Or Appropriate** means medically or visually necessary for the restoration or maintenance of a *covered person's* visual acuity and health and for which there is no less expensive professionally acceptable alternatives.

CGP-3-VSN-96-DEF17

B750.0482



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## STATEMENT OF ERISA RIGHTS

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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**

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B800.0048

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

B800.0055

The Guardian is located at 7 Hanover Square, New York, New York 10004.

B800.0049

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## Group Health Benefits Claims Procedure

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

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

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

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

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

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

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

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

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

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

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

## Group Health Benefits Claims Procedure (Cont.)

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

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

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

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

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

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

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

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

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

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

## Group Health Benefits Claims Procedure (Cont.)

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

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

### **Adverse Benefit Determination**

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

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

### **Appeal of Adverse Benefit Determinations**

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

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

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

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

## Group Health Benefits Claims Procedure (Cont.)

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- 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

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

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

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

B800.0086



**This part of your booklet is your Managed DentalGuard dental care plan.**

**None of the following provisions apply to any of your other insurance coverages.**

B850.1559

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## GENERAL PROVISIONS

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As used in this booklet:

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

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

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

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

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

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### Limitation of Authority

No agent is authorized to alter or amend this *plan*, to waive any conditions or restrictions contained herein, to extend the time for paying a premium or to bind The Guardian by making any promise or representation or by giving or receiving any information.

No change in this *plan* shall be valid unless evidenced by an endorsement or rider hereon signed by the President, a Vice President, a Secretary, an Actuary, an Associate Actuary, an Assistant Secretary or an Assistant Actuary of The Guardian, or by an amendment hereto signed by the *planholder* and by one of the aforesaid officers of The Guardian.

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### Incontestability

This *plan* shall be incontestable after two years from its Effective Date, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this *plan* may be used in contesting the validity of his or her coverage or 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 or her lifetime.

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

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### Examination

We have a right to have a doctor or dentist of our choice examine the person for whom a claim is being made under this *plan* as often as we feel necessary. We'll pay for all such examinations.

CGP-3-MDG3

B850.0050

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## MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

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**Enrollment Procedures** You and your *dependents* may enroll for dental coverage during any open enrollment period by filling out and signing the appropriate enrollment form and any additional material required by your *employer* and returning the materials to your *employer*, who will forward them to The Guardian. Thereafter, to obtain services you or your *dependents* need only contact the selected *primary care dentist's* office.

The Guardian will issue you and each of your *dependents*, either directly or through the representative of your *employer* stated herein, a Guardian MDG identification card, listing the *member's* name and the name, address and telephone number of his or her selected *primary care dentist*.

**Open Enrollment Period** If you do not enroll for dental coverage under this *policy* within 30 days of becoming eligible, you must wait until the next open enrollment period to enroll. The open enrollment period is a 30 day period occurring once every twelve (12) months after this *policy's* effective date, or at time intervals mutually agreed upon by your *employer* and The Guardian.

If, after initial enrollment, a *member* disenrolls from the *plan* before the open enrollment period, he or she may not re-enroll until the open enrollment period which occurs after the *member* has been without coverage for one (1) full year.

**When Your Coverage Starts** Your coverage starts on the *plan* effective date, if you are enrolled on or before the *plan* effective date. If you are not enrolled on this date, your coverage shall commence on the first day of the month following the date enrollment materials were received by The Guardian, or on the first day of the month after the end of any *employer* designated probationary period.

**When Your Dependent Coverage Starts** Except as stated above, your *dependents* shall be eligible for coverage on the same day you are eligible for coverage or on the first day of the month following the date on which you acquire such *dependent*, whichever is later.

If your *dependent* is a newborn child, his or her coverage begins on the date of birth. If your *dependent* is an adopted child, his or her coverage begins on the date of placement in the home. If your *dependent* is a newborn adopted child, his or her coverage begins on the date of birth if a written agreement to adopt such child is entered into prior to birth. If no such agreement exists prior to birth, or if the *dependent* is not a newborn or adopted child, you must wait until the next Open Enrollment Period to enroll such a *dependent*, unless the child is preenrolled. If preenrolled, the newborn adopted child's coverage begins on the date of placement in the home. If a newborn child, adopted child or newborn adopted child becomes covered under this *plan*, you must complete enrollment materials for such a *dependent* within 30 days of his or her effective date of coverage. Coverage does not terminate if enrollment materials are not received within 30 days.

## Member Eligibility And Termination Provisions (Cont.)

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**When Coverage Ends** Subject to any continuation of coverage which may be available to *you* or your *dependents*, your and your *dependent's* coverage under this *plan* ends when your *employer's* coverage terminates. Your and your *dependent's* coverage also ends following the first of the following events:

- (1) Upon your failure to pay the required premium to The Guardian in accordance with the provisions of this *plan*, if *you* are required to pay any part of this *plan*.
- (2) The end of the month in which *you* or your *dependents* cease to be eligible for coverage under this *plan*.
- (3) The end of the month in which your *dependent* is no longer a *dependent* as defined in this *plan*.
- (4) When *you* or your *dependent* no longer resides or works in the *service area*.
- (5) The end of the month during which your *employer* receives written notice from *you* requesting termination of coverage for *you* or your *dependents*, or on such later date as requested by the notice.
- (6) The date of your or your *dependent's* entry into active military duty, except for temporary duty of 31 days or less;
- (7) 45 days after written notification is sent to *you* advising that your or your *dependent's* coverage will terminate because a *patient charge* or other payment required under the *plan* has not been made;
- (8) 45 days after advance written notification is sent to *you* advising that coverage will terminate because *you* or your *dependent* have knowingly given false information in writing on an enrollment form, or have misused an identification card or other documents provided to obtain benefits under this *plan*; or
- (9) 45 days after advance written notification is sent to *you* advising that your or your *dependent's* coverage will terminate because The Guardian has determined that the *member's* behavior is disruptive, unruly, abusive, unlawful, fraudulent or uncooperative to the extent that the *member's* continued participation in the *plan* seriously impairs the *plan's* ability to provide services to either the *employer* or to other *members*; or that the *member* has demonstrated an inability to maintain an appropriate dentist-patient relationship. The Guardian will:
  - (a) make a reasonable effort to resolve the problem presented by the *member*, including the use or attempted use of *member* grievance procedures;
  - (b) ascertain, to the extent possible, that the *member's* behavior is not related to the use of medical services or mental illness;
  - (c) document the problems, efforts and medical conditions on which the problem is based; and
  - (d) provide 45 days advance written notice of termination.

## Member Eligibility And Termination Provisions (Cont.)

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**Extension of Dental Benefits** If your or your *dependent's* insurance ends, we extend dental expense benefits for *you* or your *dependents* under this *plan* as explained below.

We only extend benefits for covered services if the procedure(s) are started before your or your *dependent's* coverage ends and are completed within 90 days after the date coverage ends. Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are considered to be started when the impressions are taken. Orthodontic treatment is considered to be started when the teeth are banded. Root canal treatment is considered to be started when the pulp chamber is opened.

The extension of benefits terminates upon the earlier of: (a) 90 days after your or your *dependent's* coverage ends; (b) the date *you* or your *dependent* becomes covered under another plan providing coverage for similar dental procedures. However, if the succeeding plan excludes the above services through the use of an elimination period, then the extension of benefits will terminate 90 days after your or your *dependent's* coverage ends.

We don't grant an extension if your or your *dependent's* coverage was voluntarily terminated by *you* or your *dependent*. And what we pay is based on all the terms of this *plan*.

**Dental Plan Election Procedures** Since *your employer* offers *you* Guardian PPO and/or indemnity dental as an alternative to this dental coverage, *you* may change *your* election, and enroll in the alternative coverage as follows.

If *you* switch during the open enrollment period there is no penalty for switching. If *you* switch at any other time, *you* will be considered a late entrant, and *you* are subject to the alternate coverage's late entrant penalties. *Your* coverage under this *plan* ends on the date *your* coverage under the alternate coverage starts.

If *you* change *your* election, *your* insured dependents will automatically be switched to the alternate coverage at the same time as *you*.

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## YOUR CONTINUATION RIGHTS

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*You and your dependents may be eligible to Retain coverage under this plan during any Continuation Of Coverage period or election period, necessary for your employer's compliance with requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA) and any regulations adopted thereunder, or any similar state law requiring the Continuation of Benefits for members, provided the employer continues to certify the eligibility of the member and the monthly premiums for COBRA coverage for the member continue to be paid by or through the planholder pursuant to this plan.*

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### An Important Notice About Continuation Rights

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

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### Federal Continuation Rights

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**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 only applies to any dental benefits only. In this section, these coverages are referred to as "group dental benefits."

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

**If Your Group Dental Benefits End** If your group dental benefits end due to termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months if: (a) you were not terminated due to gross misconduct; (b) you are not covered for benefits from any other group plan at the time your group dental benefits under this plan would otherwise end; and (c) you are not entitled to Medicare.

The continuation: (a) may cover you and 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 XVI of the Social Security Act on the date his or her group dental benefits would otherwise end due to your 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.

## Federal Continuation Rights (Cont.)

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To elect the extra 11 months of continuation, the qualified continuee 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; and (b) 60 days after the date the qualified continuee is determined to be disabled. If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your *employer* within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation: (a) may be elected only by the disabled qualified continuee; and (b) is subject to "When Continuation Ends."

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

**If You Die While Insured** If *you* die while insured, any qualified continuee 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 Your Marriage Ends** If your marriage ends due to legal divorce or legal separation, any qualified continuee 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'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 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 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: (a) the *dependent* becomes eligible for 36 months of group dental benefits due to any of the reasons stated above; or (b) *you* become entitled to Medicare.

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

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

Such notice must be given to your *employer* within 60 days of either of these events.

## Federal Continuation Rights (Cont.)

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**Your Employer's Responsibilities** Your *employer* must notify the qualified continuee, in writing, of: (a) his or her right to continue this *plan's* group 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.

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; or (b) the date a qualified continuee notifies your *employer*, in writing, of the your legal divorce or legal separation from your spouse, or the loss of *dependent* eligibility of a *dependent*.

**Your Employer's Liability** Your *employer* will be liable for the qualified continuee's continued group dental 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 dental 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 dental benefits, the qualified continuee 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 continuee receives notice of his or her continuation rights from your *employer* as described above. And the qualified continuee must pay his or her first month's 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 monthly premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed enrolled in the group *plan* on a regular basis. It includes any amount that would have been paid by your *employer*. Except as explained in the "Extra Continuation for Disabled Qualified Continuees" 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.

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

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



## Federal Continuation Rights (Cont.)

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- (b) with respect to a disabled qualified continuee 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 the group health benefits would otherwise end; 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 final determination is made that a disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (c) with respect to continuation upon the 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 the group dental benefits would otherwise end;
- (d) with respect to a *dependent* whose continuation is extended due to your entitlement to Medicare, the end of the 36 month period which starts on the date the group dental benefits would otherwise end;
- (e) the date the *plan* ends;
- (f) the end of the period for which the last premium payment is made;
- (g) the date he or she becomes covered under any other group dental plan which contains no limitation or exclusion with respect to any pre-existing condition of the qualified continuee; or
- (h) the date he or she becomes entitled to Medicare.

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## DENTAL EXPENSE COVERAGE

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This *plan* will cover many of the dental expenses incurred by *you* and those of your covered *dependents* who are covered for dental benefits under this *plan*. What we cover and the terms of coverage are explained below. All terms in italics are defined terms with special meanings. Their definitions are shown in the "Glossary" at the back of this booklet. Other terms are defined where they are used.

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### Managed DentalGuard - This Plan's Dental Coverage Organization

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**Managed DentalGuard** This *plan* is designed to provide quality dental care while controlling the cost of such care. To do this, this *plan* requires *members* to seek dental care from *participating dentists* that belong to Managed DentalGuard.

Managed DentalGuard is made up of *participating dentists* in a *member's* geographic area. A "*participating dentist*" is a *dentist* that has a participation agreement in force with us.

When a *member* enrolls in this *plan*, he or she will get information about The Guardian's current *participating general dentists* and a description of the *service area*. Each *member* must select from this list of *participating general dentists* a *primary care dentist* who will be responsible for coordinating all of the *member's* dental care. After enrollment, a *member* will receive a Managed DentalGuard ID card. A *member* must present this ID card when he or she goes to his or her *primary care dentist*.

All dental services covered by this *plan* must be coordinated by the *primary care dentist* whom the *member* selects upon enrolling in this *plan*. What we cover is based on all the terms of this *plan*. Read this *plan* carefully for specific benefit levels, exclusions and limitations and *patient charges*.

*You* can call The Managed DentalGuard Member Services Office if *you* have any questions after reading this material.

**Choice Of Providers** A *member* may select any available *participating general dentist* as his or her *primary care dentist*. A request to change *primary care dentists* must be made to The Guardian. Any such change will be effective the first day of the month following approval. The Guardian may require up to 30 days to process and approve any such request. All fees and *patient charges* due to the *member's* current *primary care dentist* must be paid in full prior to such a transfer.

**Specialty Referrals** A *member's primary care dentist* is responsible for providing all covered services. However, special procedures may be eligible for referral to a *participating specialist dentist*. The Guardian 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 process described below.

## Managed DentalGuard - This Plan's Dental Coverage Organization (Cont.)

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ALL SPECIALTY REFERRAL SERVICES MUST BE PRE-AUTHORIZED BY THE GUARDIAN AND COORDINATED BY A *MEMBER'S PRIMARY CARE DENTIST*. ANY *MEMBER* WHO ELECTS SPECIALIST CARE WITHOUT PRIOR REFERRAL BY HIS OR HER *PRIMARY CARE DENTIST* AND APPROVAL BY THE GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty services to be covered by this *plan*, the following referral process must be followed:

- (1) A *member's primary care dentist* must coordinate all dental care.
- (2) When the care of a *participating specialist dentist* is required, the *member's primary care dentist* must contact The Guardian and request authorization.
- (3) If the *primary care dentist's* request for specialist referral is approved, the *member* will be notified by The Guardian and instructed to contact the *participating specialist dentist* to schedule an appointment.
- (4) If the *primary care dentist's* request for specialist referral is denied, the *primary care dentist* and the *member* will be notified of the reason for the denial. If the service in question is a covered service, and no exclusions or limitations apply, the *primary care dentist* may be asked to perform the service directly, or to provide additional information.
- (5) A *member* who receives authorized specialty services is responsible for all applicable *patient charges* associated with the services provided.

When specialty dental care is authorized by The Guardian, a *member* will be referred to a *participating specialist dentist* for treatment. The Managed DentalGuard network includes *participating dentists* specializing in oral surgery, periodontics, endodontics, orthodontics and pediatric dentistry, located in the *member's service area*. If there is no *participating specialist dentist* in the *member's service area*, The Guardian will refer the *member* to a *non-participating specialist dentist* of The Guardian's choice. In no event will The Guardian pay for dental care provided to a *member* by a specialist not pre-authorized by The Guardian to provide such services.

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### **Emergency Dental Services**

The Managed DentalGuard network provides for *emergency dental services* twenty-four hours a day, seven days a week, to all *members*. The *member* should contact his or her own selected and assigned *primary care dentist*, who will make arrangements for such care. If a *member* is unable to reach his or her *primary care dentist* in an emergency during normal business hours, he or she must contact The Guardian's Member Services Department for instructions. If the *member* is unable to reach his or her *primary care dentist* in an emergency after normal business hours, the *member* may seek *emergency dental services* from any licensed *dentist*. The *member* must submit to The Guardian the bill incurred as a result of the emergency, evidence of payment, an explanation of the emergency and a description of the attempts to reach his or her *primary care dentist*, within thirty (30) days. The Guardian will reimburse the *member* for the cost of the *emergency dental services*, less any applicable *patient charge*.

## Managed DentalGuard - This Plan's Dental Coverage Organization (Cont.)

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**Out-Of-Area  
Emergency Dental  
Services** If a *member* is more than fifty (50) miles from his or her selected and assigned *primary care dentist's* office, and *emergency dental services* are required, he or she should seek care from a licensed *dentist*. Then he or she must file a claim within sixty (60) days and The Guardian will reimburse him or her within thirty (30) days for any covered emergency dental services in connection therewith, up to a maximum of fifty dollars (\$50.00) per person per incident, upon presentation of a detailed statement from the treating *dentist*, indicating all of the services provided.

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**Grievance  
Procedures** *Member* grievances are handled by The Guardian's Quality of Care Liaison or the Quality of Care Liaison's designee. The grievance process is designed to address *member* concerns quickly and satisfactorily. Grievances are generally classified into two categories: administrative grievances and health services grievances. To be responsive to *member* problems and concerns about coverage provided under this *plan*, The Guardian has established the following grievance procedures.

- (1) Questions or concerns may be directed to The Guardian either by telephone or by mail. When *member* issues or concerns are received by telephone, The Guardian's Member Service Representative documents the call and works with the *member* to resolve the issue. If the *member* wishes to document the complaint in writing, the Quality of Care Liaison sends the *member* a grievance form to complete. The Guardian considers a grievance to be a complaint made in writing. All written member issues are recorded and investigated.
- (2) No later than five (5) business days after the receipt of the written grievance, an acknowledgment letter is sent to the *member* indicating that a review is taking place. The usual response time for a resolution is within thirty (30) days.
- (3) Under the supervision of the Quality of Care Liaison, supporting documentation is collected. The dental office may be asked to provide copies of relevant dental records and radiographs, and statements of the dental provider or office personnel. The *member* may be asked to have a second opinion examination, if applicable.
- (4) Upon receipt of complete documentation, a resolution is determined based upon objective evaluation by the Quality of Care Liaison or the Quality of Care Liaison's designee. Health services issues are resolved under the supervision of the Dental Director. Issues of a complex nature and/or quality of care issues may, at the discretion of the Dental Director, be presented to the Grievance Committee for review and resolution.

The Grievance Committee may be comprised of the Dental Director or the Dental Director's designee; the Quality of Care Liaison or the Quality of Care Liaison's designee; the Director of Provider Relations; policy and compliance representatives; legal counsel and Member Services Representatives.

## Managed DentalGuard - This Plan's Dental Coverage Organization (Cont.)

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(5) If the *member* is not satisfied with the resolution, he or she may request a re-evaluation. If the issue has not been reviewed by the Grievance Committee, all documentation will be given to that Committee for its evaluation at its next regularly scheduled meeting. The *member* will then be notified of the Committee's decision within ten (10) business days following the meeting.

If the *member* is not satisfied with the Grievance Committee resolution, or if the issue was initially reviewed by that Committee and the *member* requests a re-evaluation, the *member* will receive notification that the grievance, with all supporting documentation, will be presented at the next quarterly Peer Review Committee meeting. The *member* will receive a written resolution with Peer Review recommendations within ten (10) business days following the Peer Review Committee meeting.

(6) If the *member* is not satisfied with the resolution of the Peer Review Committee, he or she may make a written request that an additional review be conducted by three individuals, a "Grievance Appeals Committee." This Committee will meet within sixty (60) days of the date the appeal is made, provided that more time shall be permitted as necessary for extraordinary circumstances. The Grievance Appeal Committee will be made up of three representatives, as follows:

- (a) One representative selected by The Guardian;
- (b) One representative selected by the *member* ; and
- (c) One representative selected from the dental community, and agreed upon by both the *member* and The Guardian. This representative shall preside over the Committee.

The *member* will provide for his or her own expenses relating to the Committee process, including the expenses of the representative the *member* selects. The Guardian will pay for its expenses relating to the Committee process, including the expenses of the representative The Guardian selects. The *member* and The Guardian will share on an equal basis the expenses of the individual who presides over the Committee.

Following the decision of the Committee, the *member* and The Guardian each have the right to use the legal system or arbitration for any claim involving the professional treatment performed by the *dentist*.

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## Covered Dental Services And Patient Charges - Plan 30 M

The services covered by this *plan* are named in this list. If a procedure is not on this list, it is not covered. All services must be provided by the *primary care dentist* selected by the *member*.

The *member* must pay the listed *patient charge*. The benefits we provide are subject to all of the terms of this *plan*, including the Limitations on Benefits for Specific Covered Services, Additional Conditions on Covered Services, and Exclusions.

These *patient charges* may not be valid in all states.

Codes+	Description of Service	Patient Charge
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### Appointments and Diagnostic Services

0101	Office Visit - during regular hours - participating general dentist only	.. \$5.00
0102	Broken Appointment (without 24 hours' notice)	..... \$25.00
0120, 0140, 0150	Oral evaluation	..... No Charge
0460	Pulp vitality tests	..... No Charge
0470	Diagnostic casts	..... No Charge
9310	Consultation (by dentist other than practitioner providing treatment)	..... No Charge
9430	Office visit for observation - regular hours - no other service performed	..... No Charge
9440	Emergency office visit - after regularly scheduled office hours	..... \$50.00

### Radiographs

0210	Intraoral - complete series (including bitewings)	..... No Charge
0220, 0230, 0240	Intraoral - periapical or occlusal - single film	..... No Charge
0270, 0272, 0274	Bitewings	..... No Charge
0330	Panoramic film	..... No Charge

### Preventive Services & Space Maintenance

1110, 1120	Prophylaxis	..... No Charge
1201, 1203	Topical application of fluoride (may include prophylaxis) - child	.. No Charge

## Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

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1310	Nutritional counseling for control of dental diseases . . . . .	No Charge
1330	Oral hygiene instruction . . . . .	No Charge
1351	Sealant - per tooth . . . . .	\$10.00
1510	Space maintainer - fixed - unilateral . . . . .	\$50.00
1515	Space maintainer - fixed - bilateral . . . . .	\$90.00
1550	Recementation of space maintainer . . . . .	\$10.00

### Restorative

2110	Amalgam - one surface - primary . . . . .	\$10.00
2120	Amalgam - two surfaces - primary . . . . .	\$10.00
2130	Amalgam - three surfaces - primary . . . . .	\$15.00
2131	Amalgam - four or more surfaces - primary . . . . .	\$15.00
2140	Amalgam - one surface - permanent . . . . .	\$10.00
2150	Amalgam - two surfaces - permanent . . . . .	\$10.00
2160	Amalgam - three surfaces - permanent . . . . .	\$15.00
2161	Amalgam - four or more surfaces - permanent . . . . .	\$15.00
2210	Silicate cement - per restoration . . . . .	\$15.00
2330	Resin/composite - one surface, anterior . . . . .	\$20.00
2331	Resin/composite - two surfaces, anterior . . . . .	\$30.00
2332	Resin/composite - three surfaces, anterior . . . . .	\$35.00
2335	Resin/composite - four or more surfaces or incisal angle, anterior . . .	\$40.00
2336	Composite resin crown, anterior - primary . . . . .	\$35.00
2380	Resin/composite - one surface, posterior - primary . . . . .	\$25.00
2381	Resin/composite - two surfaces, posterior - primary . . . . .	\$35.00
2382	Resin/composite - three or more surfaces, posterior - primary . . . . .	\$40.00
2385	Resin/composite - one surface, posterior - permanent . . . . .	\$30.00
2386	Resin/composite - two surfaces, posterior - permanent . . . . .	\$40.00

## Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

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**2387** Resin/composite - three or more surfaces, posterior - permanent . . . \$50.00  
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### Crown, Bridge & Other Cast Restorations

**2510** Inlay - metallic - one surface\* . . . . . \$155.00  
**2520, 6520** Inlay - metallic - two surfaces\* . . . . . \$190.00  
**2530, 6530** Inlay - metallic - three or more surfaces\* . . . . . \$195.00  
**2543, 6543** Onlay - metallic - three surfaces\* . . . . . \$200.00  
**2544, 6544** Onlay - metallic - four or more surfaces\* . . . . . \$215.00  
**2702** Crown supporting existing partial denture - in addition to crown . . . . \$125.00  
**2703** Multiple crown and bridge unit treatment plan - per unit . . . . . \$125.00  
**2740** Crown - porcelain/ceramic substrate . . . . . \$260.00  
**2750, 2751, 2752** Crown - porcelain fused to metal\* . . . . . \$255.00  
**2790, 2791, 2792** Crown - full cast metal\* . . . . . \$235.00  
**2810, 6780** Crown - 3/4 cast metallic\* . . . . . \$245.00  
**6210, 6211, 6212** Pontic - cast metal\* . . . . . \$235.00  
**6240, 6241, 6242** Pontic - porcelain fused to metal\* . . . . . \$255.00  
**6750, 6751, 6752** Crown - abutment - porcelain fused to metal\* . . . . . \$255.00  
**6790, 6791, 6792** Crown - abutment - full cast metal\* . . . . . \$235.00

### Other Restorative Services

**2910, 2920, 6930** Recementation inlay, crown, bridge . . . . . \$5.00  
**2930, 2931** Prefabricated stainless steel crown . . . . . \$20.00  
**2932** Prefabricated resin crown . . . . . \$55.00  
**2940** Sedative filling . . . . . \$10.00  
**2950, 6973** Core buildup, including any pins . . . . . \$50.00  
**2951** Pin retention - per tooth, in addition to restoration . . . . . No Charge  
**2952, 6970** Cast post & core . . . . . \$75.00  
**2954, 6972** Prefabricated post & core . . . . . \$60.00



## Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

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**2960** Labial veneer (lamine) - chairside . . . . . \$105.00

### Endodontics

**3110, 3120** Pulp cap . . . . . \$10.00

**3220** Therapeutic pulpotomy . . . . . \$25.00

**3310** Root canal - anterior . . . . . \$135.00

**3320** Root canal - bicuspid . . . . . \$160.00

**3330** Root canal - molar . . . . . \$230.00

**3346** Root canal - retreatment - anterior . . . . . \$165.00

**3347** Root canal - retreatment - bicuspid . . . . . \$195.00

**3348** Root canal - retreatment - molar . . . . . \$245.00

**3410** Apicoectomy/periradicular surgery - anterior . . . . . \$150.00

**3421** Apicoectomy/periradicular surgery - bicuspid - first root . . . . . \$150.00

**3425** Apicoectomy/periradicular surgery - molar - first root . . . . . \$160.00

**3426** Apicoectomy/periradicular surgery - each additional root . . . . . \$70.00

**3430** Retrograde filling - per root . . . . . \$30.00

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### Periodontics

**4210** Gingivectomy or gingivoplasty - per quadrant . . . . . \$95.00

**4211** Gingivectomy or gingivoplasty - per tooth . . . . . \$35.00

**4240** Gingival flap procedure - including root planing - per quadrant . . . . \$165.00

**4249** Clinical crown lengthening - hard tissue . . . . . \$140.00

**4260** Osseous surgery - including flap entry, closure - per  
quadrant - five to eight teeth . . . . . \$255.00

**4261** Osseous surgery - including flap entry, closure - per quadrant - one to four  
teeth . . . . . \$155.00

**4270** Pedicle soft tissue graft procedure . . . . . \$165.00

**4271** Free soft tissue graft procedure (including donor site surgery) . . . . \$180.00

**4341** Periodontal scaling & root planing - per quadrant . . . . . \$55.00

## Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

<b>4355</b>	Full mouth debridement to enable evaluation and diagnosis . . . . .	\$30.00
<b>4910</b>	Periodontal maintenance procedures (following active therapy) . . . . .	\$30.00
<b>4920</b>	Unscheduled dressing change (by other than treating dentist) . . .	No Charge
<b>9951</b>	Occlusal adjustment - limited - per visit . . . . .	\$15.00

### Prosthodontics (Removable)

<b>5110, 5120</b>	Complete denture (including routine post delivery care) . . . . .	\$290.00
<b>5130, 5140</b>	Immediate denture (including routine post delivery care) . . . . .	\$290.00

#### Partial dentures (including routine post delivery care):

<b>5211, 5212</b>	Resin base - including clasps, rests, teeth . . . . .	\$230.00
<b>5213, 5214</b>	Cast metal framework with resin base - including clasps, rests, teeth . . . . .	\$335.00

#### Repairs and adjustments:

<b>5410, 5411, 5421, 5422</b>	Denture adjustments . . . . .	\$15.00
<b>5510, 5610</b>	Repair denture base . . . . .	\$25.00
<b>5520, 5640</b>	Replace missing or broken teeth -per tooth . . . . .	\$20.00
<b>5630</b>	Repair or replace clasp . . . . .	\$25.00
<b>5650</b>	Add tooth to existing partial . . . . .	\$25.00
<b>5660</b>	Add clasp to existing partial . . . . .	\$30.00
<b>5710, 5711, 5720, 5721</b>	Rebase denture . . . . .	\$80.00
<b>5730, 5731, 5740, 5741</b>	Reline denture (chairside) . . . . .	\$45.00
<b>5750, 5751, 5760, 5761</b>	Reline denture (laboratory) . . . . .	\$65.00
<b>5820, 5821</b>	Interim partial denture (stayplate) . . . . .	\$115.00
<b>5850, 5851</b>	Tissue conditioning . . . . .	\$20.00

CGP-3-MDGL3

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## Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

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### Oral Surgery

<b>7110, 7120</b>	Extraction - single tooth . . . . .	\$10.00
<b>7130</b>	Root removal - exposed roots . . . . .	\$25.00
<b>7210</b>	Surgical removal of erupted tooth . . . . .	\$50.00
<b>7220</b>	Removal of impacted tooth - soft tissue . . . . .	\$65.00
<b>7230</b>	Removal of impacted tooth - partially bony . . . . .	\$90.00
<b>7240</b>	Removal of impacted tooth - completely bony . . . . .	\$105.00
<b>7241</b>	Removal of impacted tooth - completely bony, with unusual surgical complications . . . . .	\$110.00
<b>7250</b>	Surgical removal of residual tooth roots (cutting procedure) . . . . .	\$50.00
<b>7270</b>	Tooth reimplantation and/or stabilization of accidentally evulsed tooth	\$80.00
<b>7280</b>	Surgical exposure of impacted or unerupted tooth for orthodontic reasons . . . . .	\$115.00
<b>7281</b>	Surgical exposure of impacted or unerupted tooth to aid eruption . . .	\$80.00
<b>7285</b>	Biopsy of oral tissue - hard . . . . .	\$60.00
<b>7286</b>	Biopsy of oral tissue - soft . . . . .	\$55.00
<b>7310</b>	Alveoplasty in conjunction with extractions - per quadrant . . . . .	\$45.00
<b>7320</b>	Alveoplasty not in conjunction with extractions - per quadrant . . . . .	\$60.00
<b>7450</b>	Removal of odontogenic cyst/tumor - up to 1.25 cm . . . . .	\$75.00
<b>7451</b>	Removal of odontogenic cyst/tumor - over 1.25 cm . . . . .	\$145.00
<b>7470</b>	Removal of exostosis - maxilla or mandible . . . . .	\$110.00
<b>7510</b>	Incision & drainage of intraoral abscess . . . . .	\$35.00
<b>7960</b>	Frenectomy (separate procedure) . . . . .	\$80.00

### Orthodontic Services

<b>8601</b>	Orthodontic evaluation and consultation . . . . .	\$100.00
<b>8602</b>	Orthodontic treatment plan and records, including x-rays, study models and diagnostic photos . . . . .	\$150.00
<b>8070, 8080, 8090</b>	Comprehensive orthodontic treatment, including fabrication and insertion of fixed banding appliance and periodic visits, up to 24 months . . . . .	\$2200.00

## Covered Dental Services And Patient Charges - Plan 30 M (Cont.)

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**8670** Periodic comprehensive orthodontic treatment visit . . . . . No Charge

**8680** Orthodontic retention . . . . . \$407.00

### Miscellaneous Services

**9110** Palliative (emergency) treatment . . . . . No Charge

**9215** Local anesthesia . . . . . No Charge

+ Covered services are subject to the plan's exclusions, limitations and plan provisions. Other codes may be used to describe covered services.

\* There will be an additional patient charge for the actual cost of gold/high noble metal for these procedures.

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## Additional Conditions on Covered Services

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**General Guidelines For Alternative Procedures** In dentistry it is not uncommon for there to be a number of accepted methods of treating a specific dental condition. In those situations in which a *member* selects an *alternative procedure* over the procedure recommended by the *primary care dentist*, the *member* will be responsible for the difference between the *primary care dentist's* usual charges for the recommended procedure and the *alternative procedure*, plus the applicable *patient charge* for the recommended procedure.

When the *primary care dentist* recommends a crown, the *alternative procedure* policy does not apply, regardless of the type of crown placed (including, but not limited to, a full metal crown, porcelain fused to metal crown or porcelain crown). The *member* is responsible for the applicable *patient charge* for the crown actually placed. The *member* will be responsible for the additional cost of high noble metal, if high noble metal is selected.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be made available to the *member* before treatment begins. It is recommended that the treatment plan be presented to the *member* in writing before treatment begins, to assure that there is no confusion over his or her financial responsibility.

**Crowns, Bridges And Dentures** A crown is a covered benefit when it is recommended by the *primary care dentist*. The replacement of a crown or bridge is not covered within five (5) years of the original placement under the *plan*.

The replacement of a partial or complete denture is covered only if the existing denture cannot be made satisfactory by either reline, rebase or repair. Construction of new dentures may not exceed one (1) each in any five (5) year period from the date of previous placement under the *plan*.

The benefit for complete dentures includes all usual post- delivery care including adjustments for six months after insertion. The benefit for immediate dentures includes limited follow-up care only for six months, and does not include required future rebasing or relining procedures or a complete new denture.

## Additional Conditions on Covered Services (Cont.)

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<b>Multiple Crown/Bridge Unit Treatment Fee</b>	When a <i>member's</i> recommended treatment plan includes six (6) or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the <i>member</i> will be responsible for both the usual crown or bridge <i>patient charge</i> for each unit of crown or bridge, plus an additional charge per unit shown in the Covered Dental Services and Patient Charges section.
<b>Crown Supporting Existing Partial Denture</b>	If a crown is placed under an existing partial denture, and the crown must be customized to physically support the metal framework of the partial denture, the <i>member</i> will be responsible for the additional <i>patient charge</i> for a crown supporting an existing partial denture, as shown in the Covered Dental Services and Patient Charges section, in addition to the <i>patient charge</i> for the crown or bridge unit itself. The additional <i>patient charge</i> for a crown supporting an existing partial denture does not apply to a unit of crown or bridge for which the <i>member</i> is responsible for the additional charge for a multiple crown/bridge unit treatment plan.
<b>Pediatric Specialty Services</b>	If during a <i>primary care dentist</i> visit, a <i>member</i> under age six (6) is unmanageable, the <i>member</i> may be referred to a <i>participating pediatric specialist dentist</i> for the current treatment plan only. Following completion of that authorized pediatric treatment plan, the <i>member</i> must return to the <i>primary care dentist</i> for further services. Subsequent referrals to the <i>participating pediatric specialist dentist</i> , if any, must first be authorized by The Guardian. Any services performed by a <i>pediatric specialist dentist</i> after the <i>member's</i> sixth birthday will not be covered, and the <i>member</i> will be responsible for the <i>pediatric specialist dentist's</i> usual charges.
<b>Second Opinion Consultation</b>	<p>A <i>member</i> may wish to consult another <i>dentist</i> for a second opinion regarding services recommended or performed by his or her <i>primary care dentist</i> or by a <i>participating specialist dentist</i> through an authorized referral. To have a second opinion consultation covered by The Guardian, the <i>member</i> must call or write Member Services for authorization prior to arranging for the second opinion. We only cover a second opinion consultation when the recommended services are otherwise covered under the <i>plan</i>.</p> <p>Generally, the Member Services Representative will help the <i>member</i> identify a <i>participating dentist</i> to perform the second opinion consultation. However, a <i>member</i> may request a second opinion with a <i>non-participating general dentist</i> or <i>specialist dentist</i>. Also, the Member Service Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting <i>dentist</i>. The <i>plan's</i> benefit for a second opinion consultation is limited to fifty dollars (\$50.00). If a <i>participating dentist</i> provides the consultation, there is no cost to the <i>member</i>. If a <i>non-participating dentist</i> provides the consultation, the <i>member</i> will be responsible for the portion of the <i>non-participating dentist's</i> fee in excess of fifty dollars (\$50.00).</p>
<b>Noble And High Noble Metals</b>	The <i>plan</i> provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the <i>member</i> will be responsible for the usual <i>patient charge</i> for the inlay, onlay, crown or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

## Additional Conditions on Covered Services (Cont.)

**Orthodontic Treatment** The *plan* covers orthodontic services as listed under Covered Dental Services and Patient Charges, limited to one course of treatment per *member* per lifetime. Treatment must be preauthorized by The Guardian, and must be performed by a *participating orthodontic specialist dentist*.

The Plan covers up to 24 months of comprehensive orthodontic treatment. If treatment beyond 24 months is necessary, the *member* will be responsible for an additional charge for each additional month of treatment, based upon the *participating orthodontic specialist dentist's* contracted fee.

Orthodontic services are not covered if comprehensive treatment begins before the *member* is eligible for benefits under the *plan*. If a *member's* coverage terminates after the fixed banding appliances are inserted, the *participating orthodontist specialist dentist* will continue to honor the contracted fee arrangement in effect when the *member's* fixed banding appliances were inserted. After the termination date, the *member* will be responsible only for the usual *patient charge* for comprehensive orthodontic treatment.

After the termination date, the *member* will also be responsible for the additional monthly amount otherwise paid by the *plan*.

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 covers any and all necessary fixed and removable appliances and related visits. Retention services are covered only following a course of comprehensive orthodontic treatment covered under the *plan*. Limited orthodontic treatment and interceptive (Phase I) treatment are not covered.

The *plan* does not cover any incremental charges for orthodontic appliances 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 *plan* provides its 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 *participating orthodontic specialist dentist's* usual and customary charges.

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**Limitations On  
Benefits For  
Specific Covered  
Services**

We don't pay benefits in excess of any of the following limitations:

- Routine cleaning (prophylaxis) - two (2) in any twelve (12) month period.
- Fluoride treatment - up to the 18th birthday - two (2) in any twelve (12) month period.
- Full mouth x-rays - one (1) set in any three (3) year period unless diagnostically necessary.
- Bitewing x-rays - two (2) sets per twelve (12) month period unless diagnostically necessary.

## Additional Conditions on Covered Services (Cont.)

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- Panoramic x-rays - one (1) every three (3) years unless diagnostically necessary.
- Sealants - limited to molars, up to the 16th birthday - one (1) per tooth per three (3) year period.
- Gingival flap procedure (4240) or osseous surgery (4260, 4261) - one procedure per quadrant or area in any three (3) year period.
- Periodontal soft tissue graft procedure (4270, 4271) - one procedure per area in any three (3) year period.
- Periodontal scaling and root planing - one (1) service per quadrant in any twelve (12) month period.
- Periodontal maintenance procedure - following approved, active periodontal therapy (periodontal scaling and root planing or periodontal surgery) performed by a participating Periodontist, one (1) periodontal maintenance procedure by the Periodontist is covered within three (3) to six (6) months following completion of active periodontal therapy.
- Emergency Dental Services when more than fifty (50) miles from the *primary care dentist's* office - limited to a fifty dollar (\$50.00) reimbursement per incident.
- Reline of a complete or partial denture - limited to one (1) per denture during any twelve (12) month period.
- Rebase of a complete or partial denture - limited to one (1) per denture during any twelve (12) month period.
- Second opinion consultation - when approved by The Guardian, a second opinion consultation will be reimbursed up to fifty dollars (\$50.00).

CGP-3-MDGLMT

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## Exclusions

We won't pay for any condition for which benefits of any nature are paid, whether by adjudication or settlement, under any Workers' Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.

We won't pay for dental services performed in a hospital or related hospital fees.

We won't pay for treatment of congenital and/or developmental malformations. This exclusion will not apply to an otherwise covered service involving congenitally missing teeth or supernumerary teeth.

We won't pay for any histopathological examinations, or removal of tumors, cysts, neoplasms or foreign bodies that are not tooth related.

We won't pay for any oral surgery requiring the setting of a fracture or dislocation.

We won't pay for dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.

## Exclusions (Cont.)

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We won't pay for any treatment or appliance requested, recommended or performed, which in the opinion of the *participating dentist* is not necessary for maintaining or improving the *member's* dental health, or which is solely for cosmetic purposes.

We won't pay for precision attachments, stress breakers, magnetic retention or overdenture attachments.

We won't pay for the use of general anesthesia, intramuscular sedation, intravenous sedation, or inhalation sedation, including but not limited to nitrous oxide.

We won't pay for any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

We won't pay for replacement of a lost, missing, or stolen appliance or prosthesis or the fabrication of a spare appliance or prosthesis.

We won't pay for any *member* request for specialist services or treatment which can be routinely provided by the *primary care dentist*, or treatment by a specialist without referral from the *primary care dentist* and Managed DentalGuard approval.

We won't pay for treatment provided by any public program, except Medicaid, or paid for or sponsored by any government body, unless we are legally required to provide benefits.

We won't pay for any restoration, service, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) replace tooth structure lost due to attrition or abrasion; or (3) splint or stabilize teeth for periodontal reasons.

We won't pay for any service, appliance, device or modality intended to treat disturbances of the temporomandibular joint (TMJ).

We won't pay for dental services, other than covered emergency dental services, received from any dentist other than the selected and assigned *primary care dentist*, unless expressly authorized in writing by the *plan*.

We won't pay for cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.

We won't pay for treatment which requires the services of a Prosthodontist.

We won't pay for treatment which requires the services of a Pediatric Specialist Dentist, after the *member's* sixth birthday.

We won't pay for consultations for non-covered services.

We won't pay for any procedure not listed as a benefit.

We won't pay for any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.



## Exclusions (Cont.)

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We won't pay for inlays, onlays, onlays, crowns or fixed bridges started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared, and completed when the final restoration is permanently cemented.)

We won't pay for root canal treatment started but not completed prior to the *member's* eligibility to receive benefits under this *plan*. (Root canal treatment is considered to be started when the pulp chamber is opened, and completed when the permanent root canal filling material is placed.)

We won't pay for inlays, onlays, crowns or fixed bridges started (as defined above) by a *non-participating dentist*. This exclusion will not apply to services that were covered under the *plan* as *emergency dental services*.

We won't pay for root canal treatment started (as defined above) by a *non-participating dentist*. This exclusion will not apply to services that were covered under the *plan* as *emergency dental services*.

We won't pay for dentures, or orthodontic treatment started prior to the *member's* eligibility to receive benefits under this *plan*. (Dentures are considered to be started when the impressions are taken. Orthodontic treatment is considered to be started when the teeth are banded.)

We won't pay for extractions performed solely to facilitate orthodontic treatment.

We won't pay for extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.

We won't pay for orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.

We won't pay for procedures performed to facilitate non-covered services, including but not limited to root canal therapy to facilitate either hemisection or root amputation, and osseous surgery to facilitate either guided tissue regeneration or an osseous graft.

CGP-3-MDGEXC-FL

B850.0174

We won't pay for procedures, appliances or devices to guide minor tooth movement or to correct or control harmful habits.

We won't pay for any endodontic, periodontal, crown or bridge abutment procedure or appliance requested, recommended or performed for a tooth or teeth with a guarded, questionable or poor prognosis.

We won't pay for re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.

We won't pay for replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

CGP-3-MDGEXC2

B850.0175

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## Converting This Group Dental Insurance

<b>Important Notice</b>	This section applies only to dental expense coverages. In this section these coverages are referred to as "group dental benefits."
<b>If An Employee's Group Dental Benefits End</b>	If an <i>employee's</i> group dental benefits end for any reason, he or she can obtain a converted policy. But he or she must have been insured by this <i>plan</i> for at least 3 consecutive months immediately prior to the date his or her group benefits end. The converted policy will cover the <i>employee</i> and those of his eligible <i>dependents</i> whose group dental benefits end.
<b>If An Employee Dies While Insured</b>	If an <i>employee</i> dies while insured, after any applicable continuation period has ended, his then insured spouse can convert. The converted policy will cover the spouse and those of the <i>employee's dependent</i> children whose group dental benefits end. If the spouse is not living, each dependent child whose group dental benefits end may convert for himself or herself.
<b>If An Employee's Marriage Ends</b>	If an <i>employee's</i> marriage ends by legal divorce or annulment, and if the former spouse is dependent upon the <i>employee</i> for financial support, his or her former spouse can convert. The converted policy will cover the former spouse and those of the <i>employee's dependent</i> children whose group dental benefits end.
<b>When a Dependent Loses Eligibility</b>	When an insured <i>dependent</i> stops being an eligible <i>dependent</i> , as defined in this <i>plan</i> , he or she may convert. The converted policy will only cover the <i>dependent</i> whose group dental benefits end.
<b>How and When to Convert</b>	To convert, the applicant must apply to us in writing and pay the required premium. He or she has 31 days after his group dental benefits end to do this. We don't ask for proof of insurability. The converted policy will take effect on the date the applicant's group dental benefits end. If the applicant is a minor or incompetent, the person who cares for and supports the applicant may apply for him or her.
<b>The Converted Policy</b>	The applicant may convert to the individual dental insurance policy we normally issue for conversion at the time he or she applies. The policy will be renewable. The converted policy will comply with the laws of the State of Florida when he or she applies.

### Restrictions:

- (1) A *member* can't convert if his or her group dental benefits end because the *employee* has failed to make required payments.
- (2) A *member* can't convert if his or her discontinued coverage is replaced by similar coverage within 31 days.
- (3) A *member* can't convert if his or her coverage ends for any of the reasons listed under number (9) of the WHEN COVERAGE ENDS section of this *plan*.

CGP-3-MDG-FL-CONV

B850.0171

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## GLOSSARY

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This Glossary defines the italicized terms appearing in your booklet.

**Alternative Procedure** 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.

CGP-3-MDGD1

B850.0150

**Associated Company** means a corporation or other business entity affiliated with the *employer* through common ownership of stock or assets.

CGP-3-MDGD2

B850.0151

**Certificate of Coverage** means this document issued to *you* which summarizes the essential terms of this agreement.

CGP-3-MDGD3

B850.0152

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

CGP-3-MDGD4

B850.0153

**Dependent** means a person listed on your enrollment form who is any of the following:

1. your spouse;
2. your or your spouse's child who is less than 26 years of age.

The term "*dependent child*" as used in this *plan* will include any: (a) stepchild; (b) newborn child; (c) legally adopted child; (d) child for whom *you* are court-appointed legal guardian; or (e) proposed adoptive child, during any waiting period prior to the formal adoption if the child: (i) is a part of your household, and (ii) is primarily dependent on *you* for support and maintenance. The term also includes any child for whom a court-ordered decree requires *you* to provide *dependent* coverage.

3. A *dependent child* who has a mental or physical handicap or developmental disability, and who: (1) has reached the upper age limit of a *dependent child*; (2) is unmarried; (3) is not capable of self-sustaining work; and (4) depends primarily on *you* for support and maintenance. *You* must furnish proof of such lack of capacity and dependence to *us* within 31 days after the child reaches the limiting age, and each year after that, on *our* request.

The term "*dependent*" does not include a person who is also covered as an *employee* for benefits under any dental plan which the *planholder* offers, including this one.

CGP-3-MDG-DEF4-10

B850.1315

<b>Emergency Dental Services</b>	mean only covered, bona fide emergency 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. Services related to the initial emergency condition but not required specifically to relieve pain, discomfort, bleeding or swelling or to prevent imminent tooth loss, including services performed at the emergency visit and services performed at subsequent visits, are not considered <i>emergency dental services</i> .	
	CGP-3-MDGD6	B850.0155
<b>Employee or You</b>	means a person who works for the <i>planholder</i> at the <i>planholder's</i> place of business and whose income is reported for tax purposes using a W-2 form, or surviving spouse who is otherwise eligible for dental coverage under the eligibility requirements of this <i>plan</i> , and who is enrolled hereunder and for whom monthly payments are made by an <i>employer</i> .	
	CGP-3-MDGD7	B850.0156
<b>Employer or Planholder</b>	means the employer or other entity with whom or to whom this <i>plan</i> is issued, and who agrees to collect and pay the applicable premium on behalf of all its <i>members</i> .	
	CGP-3-MDGD8	B850.0158
<b>Member</b>	means <i>you</i> and any of your eligible <i>dependents</i> , as defined under the eligibility requirements of this <i>plan</i> and as determined by the <i>employer</i> , who are actually enrolled in and eligible to receive benefits under this <i>plan</i> .	
	CGP-3-MDGD9	B850.0159
<b>Non-Participating Dentist</b>	means any <i>dentist</i> that is not under contract with The Guardian to provide dental services to <i>members</i> .	
	CGP-3-MDGD10	B850.0161
<b>Participating General Dentist</b>	means a licensed <i>dentist</i> under contract with The Guardian who is listed in The Guardian's directory of <i>participating dentists</i> as a general practice <i>dentist</i> , and who may be selected as a <i>primary care dentist</i> by a <i>member</i> to provide or arrange for a <i>member's</i> dental services.	
	CGP-3-MDGD12	B850.0162
<b>Participating Specialist Dentist</b>	means a licensed <i>dentist</i> under contract with The Guardian as an Endodontist, Pediatric Specialist Dentist, Periodontist, Oral Surgeon or Orthodontist.	
	CGP-3-MDGD13	B850.0163
<b>Patient Charge</b>	means the amount, if any, specified in the Covered Dental Services and Patient Charges section of this <i>policy</i> which represents the patient's portion of the cost of covered dental procedures.	
	CGP-3-MDGD14	B850.0164
<b>Plan</b>	means The Guardian Group plan for Dental Services described herein.	
	CGP-3-MDGD15	B850.0165

## Glossary (Cont.)

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<b>Primary Care Dentist</b>	means a <i>participating general dentist</i> selected by a <i>member</i> who is responsible for providing or arranging for a <i>member's</i> dental services.
	CGP-3-MDGD16 B850.0166
<b>Service Area</b>	means the geographic area in which The Guardian has arranged to provide for dental services for <i>members</i> .
	CGP-3-MDGD17 B850.0167
<b>We, us, our and Guardian</b>	mean The Guardian Life Insurance Company of America.
	CGP-3-MDGD18 B850.0168

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## COORDINATION OF BENEFITS

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### Applicability

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This Coordination of Benefits provision applies when a *member* has dental coverage under more than one plan.

When a *member* has dental coverage from more than one plan, this *plan* coordinates its benefits with the benefits of all other plans so that benefits from these plans are not duplicated.

As used here:

"Plan" means any of the following that provides dental expense benefits or services:

- (1) group or blanket insurance plans;
- (2) group Blue Cross plans, group Blue Shield plans or other service or prepayment plans on a group basis;
- (3) union welfare plans, employer plans, employee benefits plans, trustee labor and management plans, or other plans for members of a group; and
- (4) Medicare or other governmental benefits, including mandatory no-fault auto insurance.

"Plan" does not include Medicaid or any other government program or coverage which we are not allowed to coordinate with by law. Plan also does not include blanket school accident-type coverage.

"This *plan*" means the part of this *plan* subject to this provision.

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### How This Provision Works: The Order of Benefits

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We apply this provision when a *member* is covered by more than one plan. When this happens we consider each plan separately when coordinating payments.

In applying this provision, one of the plans is called the primary plan. A secondary plan is one which is not a primary plan. The primary plan pays first, ignoring all other plans. If a *member* is covered by more than one secondary plan, the following rules decide the order in which the benefits are determined in relation to each other. The benefits of each secondary plan may take into consideration the benefits of any other plan which, under the rules of this section, has its benefits determined before those of that secondary plan.

If a plan has no coordination provision, it is primary. When all plans have a coordination of benefits provision, the rules that govern which plan pays first are as follows:

- (1) A plan that covers a *member* as an *employee* pays first, the plan that covers a *member* as a *dependent* pays second;

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## How This Provision Works: The Order of Benefits (Cont.)

- (2) Except for *dependent* children of separated or divorced parents, the following governs which plan pays first when the *member* is a *dependent* child of an *employee* :
  - (a) The plan that covers a *dependent* of an *employee* whose birthday falls earliest in the calendar year pays first. The plan that covers a *dependent* of an *employee* whose birthday falls later in the calendar year pays second. The *employee's* year of birth is ignored.
  - (b) If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the other plan.
- (3) For a *dependent* child of separated or divorced parents, the following governs which plan pays first when the *member* is a *dependent* of an *employee* :
  - (a) When a court order makes one parent financially responsible for the health care expenses of the *dependent* child, then that parent's plan pays first;
  - (b) If there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and
  - (c) The plan of the stepparent with custody pays before the plan of the natural parent without custody.
- (4) A plan that covers a *member* as an active *employee* or as a *dependent* of such *employee* pays first. A plan that covers a person as a laid-off or retired *employee* or as a *dependent* of such *employee* pays second.

If the plan that we're coordinating with does not have a similar provision for such persons, then (4) will not apply.

If rules (1), (2), (3) and (4) don't determine which plan pays first, the plan that has covered the person for the longer time pays first.

To determine the length of time a *member* has been insured under a plan, two plans will be treated as one if the *member* was eligible under the second within 24 hours after the first plan ended.

The *member's* length of time covered under one plan is measured from his or her first date of coverage under the plan. If that date is not readily available, the date the *member* first became a *member* of the group will be used.

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## How This Provision Works: Coordinating Benefits

### **Coordination with Another Pre-Paid Dental Plan**

A Managed DentalGuard *member* may also be covered under another pre-paid dental plan where members pay only a fixed payment amount for each covered service.

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## How This Provision Works: Coordinating Benefits (Cont.)

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For *primary care dentists'* services, when the *primary care dentist* participates under both pre-paid plans, the *member* will never be responsible for more than the Managed DentalGuard *patient charge*.

For *participating specialist dentists'* services, when this *plan* is primary, our benefits are paid without regard to the other coverage. When this *plan* is the secondary coverage, 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.

### **Coordination with Another Traditional or PPO Dental Plan**

When a *member* is covered by this *plan* and a fee-for-service plan, the following rules will apply.

For *primary care dentists'* services, when this *plan* is the primary plan, the *primary care dentist* 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* payment.

For *primary care dentists'* services, when this *plan* is the secondary plan, the *primary care dentist* 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 Specialist Dentists' services, when this *plan* is the primary plan, our benefits are paid without regard to the other coverage.

For Specialist Dentists' services, when this *plan* 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.

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## Our Right To Certain Information

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In order to coordinate benefits, we need certain information. A *member* must supply us with as much of that information as he or she can. If he or she can't give us all the information we need, we have the right to get this information from any source. If another insurer needs information to apply its coordination provision, we have the right to give that insurer such information. If we give or get information under this section, we can't be held liable for such action except as required by law.

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

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## STATEMENT OF ERISA RIGHTS

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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:

- (a) Examine, without charge, all *plan* documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the *plan* with the U.S. Department of Labor, such as detailed annual reports and plan descriptions. The documents may be examined at the plan Administrator's office and at other specified locations such as worksites and union halls.
- (b) Obtain copies of all *plan* documents and other plan information upon written request to the *plan* Administrator, who may make a reasonable charge for the copies.
- (c) Receive a summary of the *plan's* annual financial report from the Plan Administrator (if such a report is required.)

In addition to creating rights for plan participants, ERISA imposes duties upon the people, called "fiduciaries," who are responsible for the operation of your benefit plan. They have a duty to operate the plan prudently and in the interest of plan participants and beneficiaries. Your employer may not fire *you* or otherwise discriminate against *you* in any way to prevent *you* from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, *you* must receive a written explanation of the reason for the denial. *you* have the right to have your claim reviewed and reconsidered.

Under ERISA, there are steps *you* can take to enforce the above rights. For instance, *you* may file suit in a federal court if *you* request materials from the plan and do not receive them within 30 days. The court may require the plan administrator to provide the materials and pay *you* up to \$110.00 a day until *you* receive them (unless the materials were not sent because of reasons beyond the administrator's control.) If your claim for benefits is denied in whole or in part, or ignored, *you* may file suit in a state or federal court. If plan fiduciaries misuse the plan's money, or discriminate against *you* for asserting your rights, *you* may seek assistance from the U.S. Department of Labor, or file suit in a federal court. If *you* lose, the court may order *you* to pay: for example, if it finds your claim is frivolous. If *you* have any questions about your *plan*, *you* should contact the Plan Administrator. If *you* have any questions about this statement or about your rights under ERISA, *you* should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

The Guardian agrees to duly investigate and endeavor to resolve any and all complaints received from *members* with regard to the nature of professional services rendered. Any inquiries or complaints shall be made to The Guardian by writing or calling The Guardian at the address and telephone indicated herein.

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## **NOTICE OF PRIVACY PRACTICES**

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

**PLEASE REVIEW IT CAREFULLY.**

Effective: 5/01/2016

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

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

### **What is Protected Health Information (PHI):**

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

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

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

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

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

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

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

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

## **The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

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

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

B998.0051

### Guardian is required to use or disclose your PHI :

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

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

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

### Other Uses and Disclosures .

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

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

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services.
- We may use or disclose your PHI to comply with workers' compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- We may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.
- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may use or disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

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

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

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

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

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

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

**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

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

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

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

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

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

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

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

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

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**The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY**

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

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

**How to Contact Us:**

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

**Attention:**

Guardian Corporate Privacy Officer  
National Operations

**Address:**

The Guardian Life Insurance Company of America  
Group Quality Assurance - Northeast  
P.O. Box 2457  
Spokane, WA 99210-2457

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## **YOUR BENEFITS INFORMATION - ANYTIME, ANYWHERE**

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**[www.GuardianAnytime.com](http://www.GuardianAnytime.com)**

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

[GuardianAnytime.com](http://GuardianAnytime.com) - 24 hours a day, 7 days a week.

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

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

To register, go to [www.GuardianAnytime.com](http://www.GuardianAnytime.com)



**GUARDIAN<sup>SM</sup>**

**The Guardian Life Insurance  
Company of America**

7 Hanover Square  
New York, New York 10004-2616