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

Your Managed DentalGuard dental care expense insurance policy appears later in this document.

The GUARDIAN Life Insurance Company of America
A Mutual Life Insurance Company
7 Hanover Square, New York, New York 10004

Incorporated 1860 By The Laws of The State of New York

Amendment to Group Policy No. G- 00533014-

(To be attached to and made a part of the Policy)

The Policyholder and the Insurance Company hereby agree that Group Policy No. G- 00533014- is hereby amended effective June 1, 2017 as follows:

Your Employer Rider is hereby declared null and void and replaced with the revised corresponding Employer Rider attached hereto.

The Guardian Life Insurance Company of America

A Mutual Company - Incorporated 1860 by the State of New York
7 Hanover Square, New York, New York 10004

POLICYHOLDER: PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

GROUP POLICY NUMBER	DELIVERED IN	POLICY DATE
G-00533014	Florida	January 1, 2017

POLICY ANNIVERSARIES: January 1st of each year, beginning in 2018

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA (herein called the Insurance Company) in consideration of the Application for this Policy and of the payment of premiums as stated herein, **AGREES** to pay benefits in accordance with and subject to the terms of this Policy.

Premiums are payable by the Policyholder as hereinafter provided. The first premium is due on the Policy Date, and subsequent premiums are, during the continuance of this Policy, due on the 1st of each month

This Policy is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Policy.

This Policy takes effect on the Policy Date specified above.

IN WITNESS WHEREOF, THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA has caused this Policy to be executed as of May 12, 2017 which is its date of issue.

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

GROUP INSURANCE POLICY
PROVIDING
BENEFITS AS DESCRIBED HEREIN

Dividends Apportioned Annually

IMPORTANT NOTICE

Should you have any questions regarding this insurance, you may contact The Guardian Life Insurance Company at:

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

GP-1-FLDISC-93 P120.0020

SCHEDULE OF INSURANCE AND PREMIUM RATES

This plan's classifications, and the option packages of benefits which are available to covered persons who are members of each classification, are shown below.

Class Description

Class 0001 ALL ELIGIBLE EMPLOYEES

GP-1-SI P130.1566

Option Packages Available

Employees may choose from the benefit packages available to members of their class. The option packages are summarized in "Summary of Option Packages" below.

GP-1-SI P130.1710

Members of Class 0001 may choose from benefit option packages A, B, C, D, E, F, G, H, S, T, U, V, W, X, Y and Z.

GP-1-SI P130.1568

Summary of Option Packages

The following are summaries of the benefit option packages available. For a complete explanation of the benefits provided by this plan, including all limitations and exclusions, please read the entire plan.

GP-1-SI P130.1585

Option A Employee and Dependent Dental with benefits for preventive services paid at a rate of 100% and basic services paid at a rate of 80%. A benefit year deductible of $50.00 applies to the services.

GP-1-SI P130.3192

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option B Employee and Dependent Dental with benefits for preventive services paid at a rate of 100% and basic services paid at a rate of 80%. A benefit year deductible of $50.00 applies to the services.

GP-1-SI P130.3192

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option C Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 80%, major services paid at a rate of 50% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option D Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 80%, major services paid at a rate of 50% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option E Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option F Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option G Employee and dependent dental benefits. See the Managed DentalGuard portion of this document for details.

GP-1-SI P130.3738

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option H Employee and dependent dental benefits. See the Managed DentalGuard portion of this document for details.

GP-1-SI P130.3738

Employee and Dependent Vision Care Expense Insurance with various copayments for services and supplies from PPO providers, and various deductibles for services and supplies from Non-PPO providers.

GP-1-SI P130.3656

Option S Employee and Dependent Dental with benefits for preventive services paid at a rate of 100% and basic services paid at a rate of 80%. A benefit year deductible of $50.00 applies to the services.

GP-1-SI P130.3192

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option T Employee and Dependent Dental with benefits for preventive services paid at a rate of 100% and basic services paid at a rate of 80%. A benefit year deductible of $50.00 applies to the services.

GP-1-SI P130.3192

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option U Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 80%, major services paid at a rate of 50% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option V Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 80%, major services paid at a rate of 50% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option W Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option X Employee and Dependent Dental with benefits for preventive services paid at a rate of 100%, basic services paid at a rate of 90%, major services paid at a rate of 60% and orthodontic services paid at a rate of 50%. A benefit year deductible of $50.00 applies to the non-orthodontic services.

GP-1-SI P130.3185

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option Y Employee and dependent dental benefits. See the Managed DentalGuard portion of this document for details.

GP-1-SI P130.3738

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Option Z Employee and dependent dental benefits. See the Managed DentalGuard portion of this document for details.

GP-1-SI P130.3738

Employee and Dependent Vision Care Expense Insurance with a none copayment for each PPO visit and a none deductible for each Non-PPO visit.

GP-1-SI P130.3654

Options A, B, C, D, E, F, S, T, U, V, W and X — Schedule of Benefits

Employee and Dependent Dental Expense

GP-1-SI *P130.9303*

Options A, B, S and T

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

Group 1 Services . . . . . None
Group 2 Services $50.00
for each covered person

GP-1-SI P130.2939

Options C, D, E, F, U, V, W and X

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

Group 1 Services . . . . . None
Group 2 and 3 Services $50.00
for each covered person

GP-1-SI P130.2941

Options A, B, S and T

Payment Rates Payment Rate for:

Group 1 Services 100%
Group 2 Services 80%

GP-1-SI P130.2932

Options C, D, U and V

Payment Rates Payment Rate for:

Group 1 Services 100%
Group 2 Services 80%

Group 3 Services 50%
Group 4 Services 50%

GP-1-SI P130.2933

Options E, F, W and X

Payment Rates Payment Rate for:
Group 1 Services 100%
Group 2 Services 90%
Group 3 Services 60%
Group 4 Services 50%

GP-1-SI P130.2933

Options A, B, S and T

Payment Limits Benefit Year Payment Limit
for Non-Orthodontic Services - up to . . . . . $ 1,000.00

A "benefit year" is a 12 month period which starts on January 1st and ends on December 31st of each year.

GP-1-SI P130.9318

Options C, D, U and V

Payment Limits Benefit Year Payment Limit
for Non-Orthodontic Services - up to . . . . . $ 1,250.00

Orthodontic Lifetime Maximum - up to . . . . . $ 1,000.00

A "benefit year" is a 12 month period which starts on January 1st and ends on December 31st of each year.

GP-1-SI P130.9317

Options E, F, W and X

Payment Limits Benefit Year Payment Limit
for Non-Orthodontic Services - up to . . . . . $ 1,500.00

Orthodontic Lifetime Maximum - up to . . . . . $ 1,250.00

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

A "benefit year" is a 12 month period which starts on January 1st and ends on December 31st of each year.

GP-1-SI P130.4989

Options A, B, C, D, E, F, S, T, U, V, W and X

Once each year, during the group enrollment period an employee may elect to enroll in one of the dental expense plan options offered by the employer. The group enrollment period is a time period agreed to by the employer and us. Coverage starts

on the first day of the month that next follows the date of enrollment. The employee and his or her eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.

Once each year, during a special election period an employee may elect to transfer to another dental expense plan option offered by the employer. The special election period is a time period agreed to by the employer and us. Coverage under the new plan option starts on the first day of the month that follows election. Coverage under the former plan option ends on that date.

The group enrollment period and the special election periods are time periods agreed to by the employer and us. Such open enrollment period and special election period may occur during the same time period.

GP-1-SI P130.8676

Options A, C, E and G

PPO Copayments	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Contact Lenses	$25.00

Options B, D, F and H

PPO Copayments	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Necessary Contact Lenses	$25.00

Options S, T, U, V, W, X, Y and Z

PPO Provider Exam	Copayment	none

GP-1-SI P130.4364

Options A, C, E and G

Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Contact Lenses	$25.00

Options B, D, F and H

Non-PPO Cash Deductibles	Examinations	$10.00
	Standard Frames and/or Standard Lenses	$25.00
	Necessary Contact Lenses	$25.00

Options S, T, U, V, W, X, Y and Z

Non-PPO Provider Exam	Deductible	none

GP-1-SI P130.4365

Options A, C, E and G

If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan's materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.

Options A, B, C, D, E, F, G and H

Payment Rates For Covered Charges 100%

GP-1-SI P130.3516

Options S, T, U, V, W, X, Y and Z

Materials Allowance $50.00

GP-1-SI P130.4366

GP-1-SI *P130.3343*

All Options

Changes in Insurance Amounts Any increase or decrease in the amount of insurance on any individual shall become effective on the effective date of a change in the Employee's classification, except that any increase in the amount of insurance on an Employee or a Qualified Dependent eligible for benefits under an established benefit period shall become effective:

- in the case of an Employee not actively at work, on the day on which he returns to active work on a full-time basis (or the day on which his benefit period terminates, whichever is later) or
- in the case of an Eligible Dependent confined to a hospital, on the day on which the dependent is discharged from the hospital (or the day on which his benefit period terminates, whichever is later).

In no event shall the insurance of an Eligible Dependent of an Employee who is not actively at work on a full-time basis be increased or decreased prior to the date such Employee returns to active work on a full-time basis.

GP-1-SI P130.9324

Schedule of Premium Rates

The monthly premium rates, in U.S. dollars, for the insurance provided under this plan are listed below.

GP-1-SI P130.9260

Options A, B, C, D, E, F, S, T, U, V, W and X — Premium Rates

Dental Expense Insurance

GP-1-SI *P130.2834*

Options A, B, S and T Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 16.31	$ 35.44	$ 42.67	$ 63.72

GP-1-SI P130.1539

Options C, D, U and V Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 30.41	$ 61.12	$ 80.37	$ 114.18

GP-1-SI P130.1539

Options E, F, W and X Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 38.39	$ 76.54	$ 100.96	$ 142.95

GP-1-SI P130.1539

All Options — Premium Rates

Vision Care Expense Insurance

GP-1-SI *P130.3517*

Options A, C, E and G Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family

$ 6.26	$ 10.53	$ 10.74	$ 17.00

GP-1-SI P130.3518

Options B, D, F and H Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 6.95	$ 11.70	$ 11.93	$ 18.87

GP-1-SI P130.3518

Options S, U, W and Y Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 4.53	$ 7.62	$ 7.77	$ 12.30

GP-1-SI P130.3518

Options T, V, X and Z Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 4.20	$ 7.07	$ 7.21	$ 11.41

GP-1-SI P130.3518

We have the right to change any premium rate(s) set forth above at the times and in the manner established by the provision of the group plan entitled "Premiums".

GP-1-SI P130.9298

All Options

GENERAL PROVISIONS

Definitions

As used in this policy:

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

"Plan" means this group insurance policy.

"Covered person" means an employee or dependent insured by this policy.

GP-1-R-GENPRO-90 P140.0136

All Options

Incontestability

This Policy shall be incontestable after two years from its policy date, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this policy 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 policy replaces the group policy of another insurer, we may rescind this policy based on misrepresentations made in the policyholder's or a covered person's signed application for up to two years from this policy's policy date.

GP-1-R-INCY-90 P140.0150

All Options

Associated Companies

An associated company is a corporation or other business entity affiliated with the policyholder through common ownership of stock or assets.

If the policyholder asks us in writing to include an associated company under this policy, and we give our written approval, we'll treat employees of that company like the policyholder's employees. Our written approval will include the starting date of the company's coverage under this policy. But each eligible employee of that company must still meet all of the terms and conditions of this policy before he'll be insured.

The policyholder must notify us in writing when a company stops being associated with him. On the date a company stops being an associated company, this policy will end for all of that company's employees, except those employed by the policyholder or another covered associated company as eligible employees, on such date.

GP-1-R-AC-90 P140.0151

All Options

Premiums

Premiums due under this policy must be paid by the policyholder at an office of the Guardian or to a representative that we have authorized. The premiums must be paid as specified on the first page of this policy, unless by agreement between the policyholder and the Guardian, the interval of payment is changed. In that event, adjustment will be made to provide for payment annually, semi- annually, quarterly or monthly.

The premium due under this policy on each policy due date will be the sum of the premium charges for the insurance coverages provided under this policy. The premium charges are based upon the rates set forth in this policy's "Schedule of Insurance and Premium Rates" section.

However, we may change such rates: (a) on the first day of any policy month; (b) on any date the extent or terms of coverage for a policyholder are changed by amendment of this policy; (c) on any date our obligation under this policy with respect to a policyholder is changed because of statutory or other regulatory requirements; or (d) if this policy supplements, or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan, or health maintenance organization, on any date our obligation under this policy is changed because of a change in such other benefits.

We must give the policyholder 45 days written notice of the rate change. Such change will apply to any premium due on and after the effective date of the change stated in such notice.

Adjustment of Premiums Payable Other Than Monthly or Quarterly

Under the above provision, if a premium rate is changed after an annual or semi-annual premium became payable with respect to coverage on and after the date of such change, the premium will be adjusted by a proportionate increase or decrease for the unexpired period for which the premium became payable. If the adjustment results in a decrease, the amount of the decrease will be paid to the policyholder by us. If the adjustment results in an increase, the amount of the increase will be considered a premium due on the date of the rate change. This policy's grace period provisions will apply to any such premium due.

Grace in Payment of Premiums - Termination of Policy

A grace period of 60 days, without interest charge, will be allowed the policyholder for each premium payment except the first. If any premium is not paid before the end of the grace period, this policy automatically ends at the end of the grace period. However, if the policyholder gives us advance written notice of an earlier termination date during the grace period, this policy will end as of such earlier date.

If this policy ends during or at the end of the grace period, the policyholder will still owe us premium for all the time this policy was in force during the grace period.

This policy ends immediately on any date when an insurance coverage under this policy ends and, as a result, no benefits remain in effect under this policy.

GP-1-R-PREM-90 P140.0489

All Options

Term of Policy - Renewal Privilege

This policy is issued for a term of one (1) year from the policy date shown on the first page of this policy. All policy years and policy months will be calculated from the policy date. All periods of insurance hereunder will begin and end at 12:01 A.M. Standard Time at the policyholder's place of business.

If this policy provides coverage on a non-contributory basis, 100% of the employees eligible for insurance must be enrolled for coverage. If dependent coverage is provided on a non-contributory basis, all eligible dependents must be enrolled.

The policyholder may renew this policy for a further term of one (1) year, on the first and each subsequent policy anniversary. All renewals are subject to the payment of premiums then due, computed as provided in this policy's "Premiums" section.

However, provided we give the policyholder 45 days advance written notice, we have the right to decline to renew this policy, or any coverage hereunder on any policy anniversary or premium due date, if, on that date: (a) less than 10 employees are insured under this policy; or (b) with respect to a non-contributory policy, less than 100% of those employees eligible are insured under this policy; or (c) with respect to a contributory policy, less than 75% of those employees eligible are insured under this policy.

P140.0596

- with respect to contributory Vision Care Expense insurance, less than 25% of those employees who are eligible for insurance under this plan are insured; or

If this policy provides dependents coverage, provided we give the policyholder 45 days advance written notice, we may decline to renew such coverage on any policy anniversary or premium due date, if: (a) with respect to a non-contributory policy, less than 100% of all eligible dependents are enrolled for coverage under this policy; or (b) with respect to a contributory policy, less than 75% of those employees eligible for dependents coverage are insured as such.

The policyholder may cancel this policy at any time by giving us 31 days advance written notice. This notice must be sent to our Home Office. And the employer will owe us all unpaid premiums for the period this plan is in force.

The Contract

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

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

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

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

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

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

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

GP-1-R-TERM-FL-90 P140.0597

All Options

Clerical Error - Misstatements

Neither clerical error by the policyholder, a participating employer or the Guardian in keeping any records pertaining to insurance under this policy, nor delays in making entries thereon, will invalidate insurance otherwise validly in force or continue insurance otherwise validly terminated. However, upon discovery of such error or delay, an equitable adjustment of premiums will be made.

Premium adjustments involving return of unearned premium to the policyholder will be limited to the period of 90 days preceding the date of our receipt of satisfactory evidence that such adjustments should be made.

If the age of an employee, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of premiums will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of insurance, the true facts will be used in determining whether insurance is in force under the terms of this policy, and in what amount.

Statements

No statement will void the insurance under this policy, or be used in defense of a claim hereunder unless: (a) in the case of the policyholder, it is contained in the application signed by him; or (b) in the case of a covered person, it is contained in a written instrument signed by him.

All statements will be deemed representations and not warranties.

GP-1-R-CE-90 P140.0309

All Options

Assignment

An employee's right to assign any interest under this policy is governed as follows:

- Any death benefits (including any basic term life, supplemental term life, optional term life or accidental death and dismemberment coverages) provided by this policy, may not be assigned.
- With respect to accident and health insurance, both the employee's certificate and his right to insurance benefits under this policy are not assignable. However, the employee may direct us, in writing, to pay hospital, surgical, major medical, or dental benefits to the recognized provider who provided the covered service for which benefits became payable. We may honor such request at our option. But, the employee may not assign his right to take legal action under this policy to such provider. And we assume no responsibility as to the validity or effect of any such direction.

Assignment By Policyholder

Assignment or transfer of the interest of the policyholder will not bind us without our written consent thereto.

GP-1-R-ASSIGN-90 P140.0165

All Options

Dividends

The portion, if any, of the divisible surplus of the Guardian allocable to this policy at each policy anniversary will be determined annually by the Board of Directors of the Guardian and will be credited to this policy as a dividend on such anniversary, provided this policy is continued in force by the payment of all premiums to such anniversary.

Any dividend under this policy will be paid to the policyholder in cash, or at the option of the policyholder it may be applied to the reduction of the premiums then due.

In the event that the employees are contributing toward the cost of the coverage under any group policy issued to the policyholder and the aggregate dividends under this policy and any other group policy or policies issued to the policyholder are in excess of the policyholder's share of the aggregate cost, such excess will be applied by the policyholder for the sole benefit of the employees.

Payment of any dividend to the policyholder will completely discharge our liability with respect to the dividend so paid.

GP-1-R-DIV-90 P140.0168

All Options

Employee's Certificate

We will issue to the policyholder, for delivery to each employee insured under this policy, a certificate of coverage. The certificate will state the essential features of the insurance to which the employee is entitled and to whom the benefits are payable. But the certificate does not constitute a part of this policy and will in no way modify any of the terms and conditions set forth in this policy.

In the event this policy is amended, and such amendment affects the material contained in the certificate of coverage, a rider or revised certificate reflecting such amendment will be issued to the policyholder for delivery to affected employees.

Claims of Creditors

Except when prohibited by the laws of the jurisdiction in which this policy was issued, the insurance and other benefits under this policy will be exempt from execution, garnishment, attachment, or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

Records - Information To Be Furnished.

The policyholder must keep a record of the insured employees containing, for each employee, the essential particulars of the insurance which apply to the employee. The policyholder must periodically forward to us, on our forms, such information concerning the employees in the classes eligible for insurance under this policy as may reasonably be considered to have a bearing on the administration of the insurance under this policy and on the determination of the premium rates. For benefits which are based on an employee's salary, changes in an employee's salary must promptly be reported to us. The policyholder's payroll and other such records which have a bearing on the insurance must be furnished to us at our request at any reasonable time.

GP-1-R-CERT-90 P140.0167

All Options

Accident And Health Claims Provisions

An employee's right to make a claim for any accident and health benefits provided by this plan is governed as follows:

Notice: The employee 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 his name and plan number. If the claim is being made for one of the employee's covered dependents, the dependent's name should also be noted.

Proof of Loss: We'll furnish the employee 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. The employee must detail the nature and extent of the loss for which the claim is being made. He must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, the employee 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, he must send us written proof of loss within 90 days of the date we request. For any other loss, he must send us written proof within 90 days of the loss.

Late Notice or Proof: We won't void or reduce a claim if the employee can't send us notice or proof of loss within the required time. But he 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 the employee submits periodic written proof of loss as stated above. We'll pay all other accident and health benefits to which the employee's entitled as soon as we receive written proof of loss.

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

When the employee files proof of loss, he 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 the employee that a particular provider must provide such care. And the employee may not assign his right to take legal action under this plan to such provider.

Limitation of Actions: The employee can't bring a legal action against this plan until 60 days from the date he files proof of loss. And he can't bring legal action against this plan after three years from the date he files 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 Worker's Compensation.

GP-1-R-AH-90 P140.0169

All Options

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if:

(a) the employer is subject to the "Federal Continuation Rights" section, and therefore;

(b) the section applies to the employee.

GP-1-R-NCC-87 P240.0058

All Options

Federal Continuation Rights

Important Notice: This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states' Health Insurance Marketplaces. Please read the information contained in this notice 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 an Employee's Group Health Benefits End: If an employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, if he or she was not terminated due to gross misconduct.

The continuation: (a) may cover the employee 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 the employee's termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person's family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, a qualified continuee must give you 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 you within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

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

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

GP-1-R-COBRA-96-1 P235.0399

All Options

If an Employee Dies While Insured: If an employee dies 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".

GP-1-R-COBRA-96-2 P235.0096

All Options

If an Employee's Marriage Ends: If an employee's 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 the employee's 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 the employee's 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 the employee becomes 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 the employee's 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 the employee's termination of employment or reduction of work hours; or (b) 36 months from the date of the employee's earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities: A person eligible for continuation under this section must notify you, in writing, of: (a) the legal divorce or legal separation of the employee from his or her 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 you by a qualified continuee within 60 days of the latest of: (a) the date on which the event 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 you and this plan's procedures for providing such notice.

Notice of a disability determination must be given to you 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 you 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.

Such notice must be given to you within 60 days of either of these events.

All Options

Your 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.

You must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) the employee's death; (b) the employee's termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) the employee's Medicare entitlement; or (d) in the case of a retired employee, your bankruptcy proceeding under Title 11 of the United States Code.

Upon receipt of notice of a qualifying event from an 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 you are also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, you 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 you determine that an individual is not eligible for continued group health benefits under this plan, you must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

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

Your Liability: You will be liable for the qualified continuee's continued group health benefits to the same extent as, and in place of, us, if: (a) you fail 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) you fail 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 you 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 you 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 you, by the qualified continuee, in advance, at the times and in the manner specified by you. 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 you. 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 you.

If the qualified continuee fails to give you 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 you notify the qualified continuee of the amount of the deficiency and grant 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 you.

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

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

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

(3) with respect to continuation upon the employee's death, the employee's 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 you cease 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.

All Options

Uniformed Services Continuation Rights

An employee who enters or returns from military service, may have special rights under this plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If an employee's group health benefits under this plan would otherwise end because he or she enters into active military service, this plan will allow the employee, or his or her 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 the employee is 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 the employee fails to return to work in a timely manner after military service ends as provided under USERRA. You must provide the employee with details about this continuation provision including required premium payments.

Options A, B, C, D, E, F, S, T, U, V, W and X

ELIGIBILITY FOR DENTAL COVERAGE

P489.0005

Options A, B, C, D, E, F, S, T, U, V, W and X

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0 P180.0168

Options A, B, C, D, E, F, S, T, U, V, W and X

Enrollment Requirement: If an employee must pay part of the cost of employee coverage, we won't insure him until he enrolls in the plan and agrees to make the required payments. If he does this: (a) more than 31 days after he first becomes eligible; or (b) after he previously had coverage which ended because he failed to make a required payment, we will consider the employee to be a late entrant.

If an employee initially waived dental coverage under this plan because he or she was covered under another group plan, and he or she now elects to enroll in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to him or her with regard to dental coverage provided his or her coverage under the other plan ends due to one of the following events:

(a) termination of his or her spouse's employment;

(b) loss of eligibility under his or her spouse's plan;

(c) divorce;

(d) death of his or her spouse; or

(e) termination of the other plan.

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

GP-1-EC-90-2.0 P180.0963

Options A, B, C, D, E, F, S, T, U, V, W and X for Class 0001

Dental Plan Election Procedures: Since you offer your employees Managed DentalGuard as an alternative to this dental coverage, each employee who is enrolled in this coverage may change his or her election, and enroll in Managed DentalGuard as follows.

If the employee drops his or her coverage under this plan, at any time other than during an open enrollment period, he or she may not enroll in Managed DentalGuard until the open enrollment period which starts at least 12 months after the date coverage is dropped.

If the employee remains covered under this plan, he or she may change his or her election, and enroll in Managed DentalGuard during an open enrollment period. The employee's coverage under this plan ends on the date coverage under Managed DentalGuard begins.

An "open enrollment period" is a 30 day period occurring once every 12 months after this plan's effective date, or at time intervals agreed upon by the employer and us.

If an employee changes his or her election, the employee's covered dependents will automatically be switched to Managed DentalGuard at the same time as the employee.

GP-1-EC-90-2.0 P489.0108

Options A, B, C, D, E, F, S, T, U, V, W and X

The Waiting Period: Employees in an eligible class are eligible for dental insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0 P489.0004

Options A, B, C, D, E, F, S, T, U, V, W and X

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0 P180.0328

Options A, B, C, D, E, F, S, T, U, V, W and X

When Employee Coverage Starts

An employee must be actively at work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all of the conditions of eligibility which apply to him or her. If an employee is not actively at work on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he or she was actively at work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The scheduled effective date of an employee's coverage is as follows:

- If an employee must pay part of the cost of employee coverage, then he or she must elect to enroll and agree to make the required payments. If he or she does this on or before the eligibility date, or within 31 days of his or her eligibility date, coverage is scheduled to start on his or her eligibility date. If he or she does this more than 31 days after his or her eligibility date, his coverage is scheduled to start on the date he or she signs his or her enrollment form.
- On non-contributory plans, subject to all the terms of this plan, an employee's coverage is scheduled to start on his or her eligibility date.

GP-1-EC-90-6.0 P489.0245

Options A, B, C, D, E, F, S, T, U, V, W and X for Class 0001

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0 P489.0006

Options A, B, C, D, E, F, S, T, U, V, W and X for Class 0001

When Active Service Ends: You may continue an employee's dental expense insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.

- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

Options A, B, C, D, E, F, S, T, U, V, W and X

An Employee's Right To Continue Group Insurance During A Family Leave Of Absence

Important Notice: This section may not apply to your plan. The employee must contact you to find out if you must allow for a leave of absence under federal law. In that case the section applies.

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

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

- The date the employee returns 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 the employee's coverage would have ended had the employee not been on leave.
- The end of the period for which the premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.

- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin:** This term means the nearest blood relative of the employee.

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating,

GP-1-EC-90-7.0 P449.0523

Options A, B, C, D, E, F, S, T, U, V, W and X

Definitions

GP-1-EC-90-DEF-1 P180.0155

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-EC-90-DEF-2 P180.0156

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-EC-90-DEF-3 P180.0311

Class 0001

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

GP-1-EC-90-DEF-4 P180.0158

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-EC-90-DEF-6 P180.0160

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-EC-90-DEF-9 P180.0163

Options A, B, C, D, E, F, S, T, U, V, W and X

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10 P180.0164

Options A, B, C, D, E, F, S, T, U, V, W and X

Dependent Coverage

GP-1-DEP-90-1.0 P200.0305

Options A, B, C, D, E, F, S, T, U, V, W and X

Eligible Dependents For Dependent Dental Benefits: An employee's eligible dependents are: (a) his or her legal spouse; and (b) his or her dependent children who are under age 26; and who are: (i) dependent upon the employee for support; and (ii) residing with the employee, or enrolled as full-time or part-time students at accredited schools.

A dependent child who is not able to remain enrolled as a 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. The employee 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.

GP-1-DEP-90-2.0 P489.0711

Options A, B, C, D, E, F, S, T, U, V, W and X

Adopted Children and Step-Children: An employee's "unmarried dependent children" include his or her legally adopted children and, if they depend on the employee 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 employee's 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.

GP-1-DEP-90-3.0 P264.0005

Options A, B, C, D, E, F, S, T, U, V, W and X

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

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

If a claim submitted on behalf of the child is denied because the child has reached the limiting age, the employee must submit proof that: (a) the child's condition started before he or she reached the age limit; (b) the child became insured before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) the child depends on the employee for most of his or her support and maintenance.

The child's coverage ends when the employee's does.

GP-1-DEP-90-4.0 P489.0028

Options A, B, C, D, E, F, S, T, U, V, W and X

Waiver of Dental Late Entrants Penalty: If an employee initially waived dental coverage for his or her spouse or eligible dependent children because they were covered under another group plan, and he or she now elects to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events:

(a) termination of his or her spouse's employment;

(b) loss of eligibility under his or her spouse's plan;

(c) divorce;

(d) death of his or her spouse; or

(e) termination of the other plan.

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

And, the Penalty for Late Entrants provisions for dental coverage will not apply to the employee's spouse or eligible dependent children if: (a) he or she is under legal obligation to provide dental coverage due to a court-order; and (b) he or she enrolls them in the dental coverage under this plan within 30 days of the issuance of the court-order.

GP-1-DEP-90-5.0 P200.0771

Options A, B, C, D, E, F, S, T, U, V, W and X for Class 0001

When Dependent Coverage Starts: In order for an employee's dependent coverage to begin he or she 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 an employee's dependent coverage starts depends on when he or she elects to enroll his or her initial dependents and agrees to make any required payments.

If the employee does this on or before his or her eligibility date, the dependent's coverage is scheduled to start on the later of the first of the month which coincides with or next follows the employee's eligibility date and the date the employee becomes insured for employee coverage.

If the employee does this within the enrollment period, the coverage is scheduled to start on the date the employee becomes insured for employee coverage.

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

Once an employee has dependent coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents and agree to make any additional payments required for their coverage.

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

GP-1-DEP-90-6.0 P489.0249

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-DEP-90-7.0 P200.0708

Options A, B, C, D, E, F, S, T, U, V, W and X

Coverage for Newborn Children: We cover an employee's newborn child, subject to the conditions below, for dependent benefits starting from the moment of birth.

We also cover a newborn child of an insured family member (other than the employee's spouse) from the moment of birth until the earlier of: (a) the date the covered employee is no longer insured under this coverage; or (b) the end of eighteen months, starting from the moment of such child's birth.

The employee must notify us of the birth of the child within 31 days after the birth; and we will notify the employee of any additional premium that is required. If the employee provides us notice of the birth of the child within 31 days of the date of birth, no premium will be charged for the first 31 days of coverage. If the employee does not provide this notice within that 31 day period, premium will be charged from the date of birth.

Coverage for Adopted Children: We cover an employee's adopted child for dependent benefits from the date of adoption or the date of placement in the employee's home for the purpose of adoption, whichever comes first. The employee must notify us of the intent to adopt a child. In the case of a newborn child to be

adopted, we cover the child from the moment of birth but only if a written agreement to adopt such child has been entered into by the employee prior to the birth of the child. A copy of the agreement must be sent to us prior to the child's birth, or as soon thereafter as is reasonably possible.

Upon receipt of such notice or agreement, we will notify the employee of any additional premium required for such child's coverage. Premium, if any, will be charged from the date of adoption, or the date of placement for the purpose of adoption, whichever comes first. With respect to a newborn child to be adopted in accord with a written agreement, premium, if any, will be charged from the date of birth.

The employee has 31 days from the date of notification to pay the additional premium. The child's coverage will end if the employee doesn't pay the additional premium within 31 days. Coverage also ends if the child is ultimately not placed in the employee's home.

We consider an adopted child, newborn or otherwise, to be a newborn child for purposes of benefits provided.

Coverage for Foster Children: We cover an employee's foster child or other child in court-ordered temporary or other custody of the employee for dependent benefits starting from the date of placement in the employee's home. The employee must give us written notice within 31 days of the date of placement.

We will then notify the employee of any additional premium he must pay. And, the employee must pay the additional premium, if any, within 31 days from the date of notification to pay the additional premium. Premium, if any, will be charged from the date of placement. The child's coverage will end if the employee does not pay the additional premium within that 31 day period. Coverage also ends when the foster child is no longer in the custody of the employee.

GP-1-DEP-90-8.0 P489.0087

Options A, B, C, D, E, F, S, T, U, V, W and X

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

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

Dependent coverage also ends for all of an employee's dependents when the employee stops 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 an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she made the required payments, unless coverage ends earlier for other reasons.

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

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

GP-1-DEP-90-9.0 P489.0266

Options A, B, C, D, E, F, S, T, U, V, W and X

Definitions

GP-1-DEP-90-DEF-1 P200.0210

Options A, B, C, D, E, F, S, T, U, V, W and X

Eligibility Date for dependent coverage is the earliest date on which: (a) the employee has dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2 P200.0211

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-DEP-90-DEF-3 P200.0212

Options A, B, C, D, E, F, S, T, U, V, W and X

Enrollment Period means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4 P200.0213

Options A, B, C, D, E, F, S, T, U, V, W and X

Initial Dependents means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. If at this time he or she does not have any eligible dependents, but later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8 P200.0217

Options A, B, C, D, E, F, S, T, U, V, W and X

Newly Acquired Dependent means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9 P200.0218

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-DEP-90-DEF-11 P200.0220

Options A, B, C, D, E, F, S, T, U, V, W and X

We, Us, Our and **Guardian** means The Guardian Life Insurance Company of America.

GP-1-DEP-90-DEF-14 P200.0223

Options A, B, C, D, E, F, S, T, U, V, W and X

You and **Your** means the employer who purchased this plan.

GP-1-DEP-90-DEF-15 P200.0224

Options A, B, C, D, E, F, S, T, U, V, W and X

ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00533014-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

(herein called the Policyholder)

Effective January 1, 2017, this rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner will be eligible for dental 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.

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.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section;

b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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.

Dated at _____ This _____ Day of _____ , ____

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

GP-1-A-DMST-96-FL P210.0029

Options A, B, C, D, E, F, S, T, U, V, W and X

DENTAL EXPENSE INSURANCE

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

GP-1-DG2000-07-L P498.3466

Options A, B, C, D, E, F, S, T, U, V, W and X

DentalGuard Preferred - This Plan's Dental Preferred Provider Organization

This *plan* is designed to provide high quality dental care while controlling the cost of such care. To do this, the *plan* encourages a *covered person* to seek dental care from *dentists* and dental care facilities that are under contract with *Guardian's dental preferred provider organization (PPO),* which is called DentalGuard Preferred.

The dental PPO is made up of *preferred providers* in a covered person's geographic area. Use of the dental PPO is voluntary. A *covered person* may receive dental treatment from any dental provider he or she chooses. And he or she is free to change providers anytime.

This *plan* usually pays a higher level of benefits for covered treatment furnished by a *preferred provider.* Conversely, it usually pays less for covered treatment furnished by a *non-preferred provider.*

When an *employee* enrolls in this *plan,* he or she and his or her dependents receive a dental plan ID card and information about current *preferred providers.*

A *covered person* must present his or her ID card when he or she uses a *preferred provider.* Most *preferred providers* prepare necessary claim forms for the *covered person,* and submit the forms to *us.* We send the *covered person* an explanation of this *plan's* benefit payments, but any benefit payable by us is sent directly to the *preferred provider.*

What *we* pay is based on all of the terms of this *plan.* Please read this *plan* carefully for specific benefit levels, deductibles, *payment rates* and *payment limits.*

A *covered person* may call the Guardian at the number shown on his or her ID card should he or she have any questions about this *plan.*

GP-1-DGY2K-07-PPO-L P498.3473

Options A, B, S and T

Covered Charges

Whether a covered person uses the services of a *preferred provider or a non-preferred provider,* covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

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

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

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

GP-1-DGY2K-07-CC-L P498.3479

Options C, D, E, F, U, V, W and X

Covered Charges

Whether a covered person uses the services of a *preferred provider or a non-preferred provider,* covered charges are the charges listed in the fee schedule the *preferred provider* has agreed to accept as payment in full, for the dental services listed in this *plan's* List of Covered Dental Services.

To be covered by this *plan,* a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

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

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

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

GP-1-DGY2K-07-CC-L P498.3478

Options A, B, C, D, E, F, S, T, U, V, W and X

APPEALS OF ADVERSE DETERMINATIONS

If a covered person or health care provider does not agree with an adverse determination, the covered person or health care provider may submit an appeal as explained below.

The covered person or health care provider must file an appeal in writing concerning an adverse determination. The appeal should contain sufficient detail to identify the nature of the problem. Any documentation that the parties believe is relevant may be submitted to support an appeal.

The appeal should be directed to:

Group Quality Assurance - WRO
Guardian
P.O. Box 2457
Spokane, WA 99210-2457
FAX: 1-509-468-6399

The written appeal will be referred to a Group Quality Assurance Dental Review Specialist who will open a case file and conduct an investigation. In resolving an appeal, best efforts are made to obtain all relevant information, including clinical records.

The health care provider will be contacted and given the opportunity to respond to the appeal. If appropriate, the health care provider will be advised to submit copies of the patient's clinical records and any other pertinent dental information.

For dental care services under review, the appeal decision shall be made by a licensed dentist, or a panel of other appropriate health care providers with at least one licensed dentist on the panel.

An opinion will be forwarded in writing to all parties within 15 working days of the date that the appealis received by us.

Definitions:

"Adverse determination" means a utilization review determination by a private review agent, Guardian, or a health care provider acting on behalf of Guardian that:

a) a proposed or delivered dental care service which would otherwise be covered under the covered person's contract is not or was not medically necessary, appropriate, or efficient; or

b) an alternate dental service is adequate and appropriate care in accordance with accepted dental standards; and

c) may result in non-coverage of the dental service.

"Appeal" means a protest filed by a covered person, or dentist acting on behalf of a covered person, regarding an adverse determination concerning the covered person.

"Health care provider" means:

a) an individual licensed to provide dental care services in the ordinary course of business or practice of a profession and is a treating provider of the covered person; and

b) for purposes of this provision, is acting on behalf of the covered person.

Options A, B, C, D, E, F, S, T, U, V, W and X

Alternate Treatment

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

Proof of Claim

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

GP-1-DGY2K-07-AT-L P498.3502

Options A, B, S and T

Pre-Treatment Review

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

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

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

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

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

GP-1-DGY2K-07-PTR-L P498.3506

Options C, D, E, F, U, V, W and X

Pre-Treatment Review

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

A treatment plan should always be sent to *us* before *orthodontic treatment* starts.

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

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

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

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

GP-1-DGY2K-07-PTR-L P498.3505

Options A, B, C, D, E, F, S, T, U, V, W and X

Benefits From Other Sources

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

GP-1-DGY2K-07-OS-L P498.3504

Options A, B, C, D, E, F, S, T, U, V, W and X

The Benefit Provision - Qualifying For Benefits

GP-1-DGY2K-07-BEN-L P498.3507

Options A, B, S and T

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

- All Group II Services.

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

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

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

GP-1-DGY2K-07-LE-L P498.3746

Options C, D, E, F, U, V, W and X

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

- All Group II Services

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

- All Group III Services.

During the first 24 months a late entrant is covered by this *plan, we* won't pay for the following services:

- All Group IV Services.

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

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

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

GP-1-DGY2K-07-LE-L P498.3749

Options A, B, S and T

How *We* Pay Benefits For Group I and II Non-Orthodontic Services: There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate.*

The *benefit year* deductible, shown in the schedule, applies to Group II services. Each *covered person* must have covered charges from this service group which exceeds the deductible before *we* pay him or her any benefits for such charges. These charges must be incurred while the *covered person* is insured.

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

GP-1-DGY2K-07-BP-L P498.3901

Options C, D, E, F, U, V, W and X

How *We* Pay Benefits For Group I, II and III Non-Orthodontic Services: There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable *payment rate.*

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

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

GP-1-DGY2K-BP-07-L P498.3898

Options A, B, C, D, E, F, S, T, U, V, W and X

All covered charges must be incurred while insured. And what *we* pay is subject to the *benefit year payment limit* shown in the schedule and to all of the terms of this *plan.*

GP-1-DGY2K-07-BP-L P498.3934

Options E, F, W and X

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

GP-1-DG-ROLL-07-2.1-L P498.3954

Options E, F, W and X

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

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

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

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

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

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

- *Rollover Threshold* $700.00
- *Reward* (if all benefits are for services provided by a *preferred provider*) $500.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider*) $350.00
- *Bank Maximum* $1,250.00

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

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

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

- only claims incurred on or after the start of the next *benefit year* will count toward the *Rollover*

Threshold; and

- *Rewards* will not be applied to a *covered person's Bank* until the *benefit year* that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

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

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

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

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

GP-1-DG-ROLL-07-2.1-L P498.9355

Options C, D, U and V

How we pay benefits for Group IV Orthodontic Services: This *plan* provides benefits for Group IV orthodontic services only for covered dependent children who are less than 19 years old when the *active orthodontic appliance* is first placed.

We pay for Group IV covered charges at the applicable *payment rate.* There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider.*

Using the *covered person's* original treatment *plan, we* calculate the total benefit *we* will pay. *We* divide the benefit into equal payments, which *we* will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic appliance* is first placed. *We* make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan. We* limit what *we* pay for orthodontic services to the lifetime payment limit shown in the schedule. What *we* pay is based on all of the terms of this *plan.*

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan. We* limit what *we* pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan.* Based on the original treatment *plan, we* determine the portion of charges incurred by the *covered person* prior to being covered by this *plan,* and deduct them from the total charges. What *we* pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits we pay for *orthodontic treatment* won't be charged against a *covered person's benefit year payment limits* that apply to all other services.

The negotiated discounted fees for orthodontics performed by a *preferred provider* include: (a) treatment *plan* and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment,* with associated: (i) fabrication and insertion of any and all fixed *appliances;* and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic *appliances* made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in *orthodontic treatment* necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate *orthodontic treatment;* and (g) orthodontic treatment started before the member was eligible for orthodontic benefits under this *plan.*

Whether or not a charge is based on a discounted fee, it will be counted toward a *covered person's* orthodontic lifetime payment limit under this *plan.*

GP-1-DGY2K-07-OR-L P498.3941

Options E, F, W and X

How we pay benefits for Group IV Orthodontic Services: This *plan* provides benefits for Group IV orthodontic services.

We pay for Group IV covered charges at the applicable *payment rate.* There may be different *payment rates* which apply to covered charges for services from a *preferred provider* and a *non-preferred provider.*

Using the *covered person's* original treatment plan, *we* calculate the total benefit *we* will pay. *We* divide the benefit into equal payments, which *we* will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.

We make the initial payment when the *active orthodontic appliance* is first placed. *We* make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the *covered person* must remain covered by this *plan. We* limit what *we* pay for orthodontic services to the lifetime payment limit shown in the schedule. What *we* pay is based on all of the terms of this *plan.*

We don't pay for orthodontic charges incurred by a *covered person* prior to being covered by this *plan. We* limit what *we* pay for *orthodontic treatment* started prior to a *covered person* being covered by this *plan* to charges determined to be incurred by the *covered person* while covered by this *plan.* Based on the original treatment plan, *we* determine the portion of charges incurred by the *covered person* prior to being covered by this *plan,* and deduct them from the total charges. What *we* pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the *orthodontic treatment* started.

The benefits we pay for *orthodontic treatment* won't be charged against a *covered person's benefit year payment limits* that apply to all other services.

The negotiated discounted fees for orthodontics performed by a *preferred provider* include: (a) treatment plan and records, including initial, interim and final records; (b) orthodontic retention, including any and all necessary fixed and removable appliances and related visits; and (c) limited, interceptive and comprehensive *orthodontic treatment,* with associated: (i) fabrication and insertion of any and all fixed appliances; and (ii) periodic visits.

There is a separate negotiated discounted fee for *orthodontic treatment* which extends beyond 24 consecutive months.

The negotiated discounted fee for orthodontics performed by a *preferred provider* does not include: (a) any incremental charges for orthodontic appliances made with clear, ceramic, white lingual brackets or other optional material; (b) procedures, appliances or devices to guide minor tooth movement or to correct harmful habits; (c) retreatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident; (d) replacement or repair of orthodontic appliances damaged due to the neglect of the patient; (e) orthognathic surgery and associated incremental charges; (f) extractions performed solely to facilitate orthodontic treatment; and (g) orthodontic treatment started before the member was eligible for orthodontic benefits under this *plan.*

Whether or not a charge is based on a discounted fee, it will be counted toward a *covered person's* orthodontic lifetime payment limit under this *plan.*

GP-1-DGY2K-07-OR-L P498.3942

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-DGY2K-FL P498.0085

Options A, B, S and T

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

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 80%

GP-1-DGY2K-07-PR-L P498.4117

Options C, D, U and V

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

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 80%
- Benefits for Group II Services performed by a *non-preferred provider* 80%
- Benefits for Group III Services performed by a *preferred provider* 50%
- Benefits for Group III Services performed by a *non-preferred provider* 50%
- Benefits for Group IV Services performed by a *preferred provider* 50%

- Benefits for Group IV Services performed by a *non-preferred provider* 50%

GP-1-DGY2K-07-PR-L P498.4118

Options E, F, W and X

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

- Benefits for Group I Services performed by a *preferred provider* 100%
- Benefits for Group I Services performed by a *non-preferred provider* 100%
- Benefits for Group II Services performed by a *preferred provider* 90%
- Benefits for Group II Services performed by a *non-preferred provider* 90%
- Benefits for Group III Services performed by a *preferred provider* 60%
- Benefits for Group III Services performed by a *non-preferred provider* 60%
- Benefits for Group IV Services performed by a *preferred provider* 50%
- Benefits for Group IV Services performed by a *non-preferred provider* 50%

GP-1-DGY2K-07-PR-L P498.4118

Options A, B, S and T

After This Insurance Ends: *We* don't pay for charges incurred after a *covered person's* insurance ends.

GP-1-DGY2K-END-07-L P498.4229

Options C, D, E, F, U, V, W and X

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

We pay benefits for *orthodontic treatment* to the end of the month in which the *covered person's* insurance ends.

GP-1-DGY2K-END-07-L P498.4227

Options A, B, C, D, E, F, S, T, U, V, W and X

Extended Dental Expense Benefits

If a *covered person's* insurance ends, we extend dental expense benefits for that *covered person* under this *plan* as explained below.

We only extend benefits for covered charges for dental procedures, if the procedures: (a) are recommended in writing and begin before the *covered person's* insurance ends; (b) are for other than routine examination, prophylaxis, x-rays, sealants or orthodontic services; and (c) are performed within 90 days after the *covered person's* insurance ends. And what we pay is based on all of the terms of this *plan.*

Benefits will be paid until the earliest of: (a) the date all work is completed; (b) 90 days after the *covered person's* insurance ends; or (c) the date the *covered person* becomes covered under another dental plan providing coverage for similar dental procedures. However, if the succeeding plan excludes dental services through the use of a waiting period, then the extension of benefits will not terminate.

We don't grant an extension if the *covered person's* insurance ended because of a voluntary termination of coverage or because of failure to make required payments.

GP-1-DGY2K-EXT-FL P498.0450

Special Limitations

GP-1-DGY2K-LMT-07-L P498.4230

Options A, B, C, D, E, F, S, T, U, V, W and X

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

GP-1-DGY2K-TL-07-L P498.4239

Options A, B, S and T

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

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

GP-1-DGY2K-PP-07-L P498.4233

Options C, D, E, F, U, V, W and X

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

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

Options A, B, S and T

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*

- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this *plan.*
- Any service 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.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.
- Replacing an existing *appliance* or *dental prosthesis* with a like or unlike *appliance* or *dental prosthesis;* unless(1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are paid by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- *Orthodontic treatment,* unless the benefit provision provides specific benefits for *orthodontic treatment.*

Options C, D, E, F, U, V, W and X

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this *plan's* List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this *plan.*
- Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.
- Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.
- Overdentures and related services, including root canal therapy on teeth supporting an overdenture.
- Any restoration, procedure, *appliance* or *prosthetic device* used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this *plan* covers *orthodontic treatment;* (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this *plan.*
- The use of local anesthetic.
- Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the *orthodontic treatment* plan and records for a covered course of *orthodontic treatment.*
- Replacement of a lost, missing or stolen *appliance* or *dental prosthesis* or the fabrication of a spare *appliance* or *dental prosthesis.*
- Prescription medication.
- Desensitizing medicaments and desensitizing resins for cervical and/or root surface.
- Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.
- Pulp vitality tests or caries susceptibility tests.
- Bite registration or bite analysis.
- Gingival curettage.
- The localized delivery of chemotherapeutic agents.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.
- Temporary or provisional *dental prosthesis* or *appliances* except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this *plan.*
- Any service 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.
- Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a *dental prosthesis;* (2) facings on a *dental prosthesis* for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.

- Replacing an existing *appliance* or *dental prosthesis* with a like or unlike *appliance* or *dental prosthesis;* unless(1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the *covered person's* mouth in an *injury* suffered while insured, and can't be made serviceable.
- A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.
- The replacement of extracted or missing third molars/wisdom teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance, dental prosthesis,* modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).
- Treatment needed due to: (1) an on-the-job or job-related *injury;* or (2) a condition for which benefits are paid by Worker's Compensation or similar laws.
- Treatment for which no charge is made. This usually means treatment furnished by: (1) the *covered person's* employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.
- Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.
- The repair of an orthodontic *appliance.*
- The replacement of a lost or broken orthodontic retainer.

GP-1-DGY2K-EXCH-FL-07-L P498.4255

Options A, B, S and T

List Of Covered Dental Services

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

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

GP-1-DNTL-90-13 P490.0148

Options C, D, E, F, U, V, W and X

List Of Covered Dental Services

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

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

GP-1-DNTL-90-13 P490.0048

Options A, B, C, D, E, F, S, T, U, V, W and X

Group I - Preventive Dental Services (Non-Orthodontic)

GP-1-DNTL-90-14 P498.8633

Options A, B, C, D, E, F, S, T, U, V, W and X

Prophylaxis and Fluorides

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

- Adult prophylaxis covered age 12 and older.

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

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

Office Visits, Evaluations and Examination

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

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

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

GP-1-DNTL-90-14 P498.5008

Options A, B, C, D, E, F, S, T, U, V, W and X

Radiographs - Allowance includes evaluation and diagnosis. Also see BASIC DENTAL SERVICES, Radiographs.

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

GP-1-DNTL-90-14 P498.2169

Options A, B, C, D, E, F, S, T, U, V, W and X

Group II - Basic Dental Services
(Non-Orthodontic)

Diagnostic services - Allowance includes examination and diagnosis.

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

Diagnostic Services: Allowance includes examination and diagnosis.

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

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

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

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

Resin restorations - limited to *anterior teeth* only. Coverage for resins on *posterior teeth* is limited to the corresponding amalgam benefit. Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin

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

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

GP-1-DNTL-90-15 P498.2892

Options A, B, C, D, E, F, S, T, U, V, W and X

Space Maintainers

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

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

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

Fixed and Removable Appliances

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

GP-1-DNTL-90-15 P498.0182

Options A, B, C, D, E, F, S, T, U, V, W and X

Radiographs - Allowance includes evaluation and diagnosis. Also see PREVENTIVE DENTAL SERVICES, Radiographs.

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

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

Other diagnostic radiographs:

- Intraoral periapical or occlusal films - single films

GP-1-DNTL-90-15 P498.2170

Options A, B, C, D, E, F, S, T, U, V, W and X

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

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

GP-1-DNTL-90-15 P498.0222

Options A, B, C, D, E, F, S, T, U, V, W and X

Other Services

Injectable antibiotics needed solely for treatment of a dental condition.

GP-1-DNTL-90-15 P498.0237

Options A, B, C, D, E, F, S, T, U, V, W and X

Dental Sealants

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

GP-1-DNTL-90-15 P498.1087

Options C, D, E, F, U, V, W and X

Group III - Major Dental Services
(Non-Orthodontic)

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

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

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

Cast post and core in addition to a unit of crown or bridge, per tooth

Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth

Crown or core buildup, including pins
Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic.
Abutment supported crown

Implant supported crown
Abutment supported retainer for fixed partial denture
Implant supported retainer for fixed partial denture
Implant/abutment supported fixed denture for completely edentulous arch
Implant/abutment supported fixed denture for partially edentulous arch

Options C, D, E, F, U, V, W and X

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

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

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

Bridge Pontics

Resin with metal
Porcelain
Porcelain with metal
Full cast metal

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

Complete or Immediate dentures, upper or lower

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

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

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

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

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

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

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

Simple stress breakers, per unit

Options C, D, E, F, U, V, W and X

Crown and Prosthodontic Restorative Services - Also see the "Major Restorative Services" section.

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

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

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

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

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

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

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

Denture adjustments - Denture adjustments done within 12 months are considered to be part of the denture placement when the adjustment is done by the *dentist* who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

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

Options C, D, E, F, U, V, W and X

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

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

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

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

Options C, D, E, F, U, V, W and X

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

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

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

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

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

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

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

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

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

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

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

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

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

Periodontal surgery related

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

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

Options C, D, E, F, U, V, W and X

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

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

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

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

Options C, D, E, F, U, V, W and X

General Anesthesia

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

Options C, D, E, F, U, V, W and X

Group IV - Orthodontic Services

Orthodontic Services

- Any covered Group I, II or III service in connection with *orthodontic treatment.*
- Transseptal fiberotomy
- Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.
- Treatment *plan* and records, including initial, interim and final records.
- Limited *orthodontic treatment,* Interceptive orthodontic treatment or Comprehensive *orthodontic treatment,* including fabrication and insertion of any and all fixed *appliances* and periodic visits.

- Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

GP-1-DNTL-90-17 P498.0083

Options A, B, S and T

Definitions

The terms that are italicized throughout this *plan,* are defined in this section.

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

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

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

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

GP-1-DGY2K-D1-07-L P498.4496

Options C, D, E, F, U, V, W and X

Definitions

The terms that are italicized throughout this *plan,* are defined in this section.

Active Orthodontic means an *appliance,* like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

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

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

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

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

GP-1-DGY2K-D1-07-L P498.4495

Options A, B, C, D, E, F, S, T, U, V, W and X

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

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

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

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

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

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

Options A, B, S and T

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

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

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

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

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

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

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

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

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

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

Options C, D, E, F, U, V, W and X

Non-Preferred Provider means a *dentist* or dental care facility that is not under contract with DentalGuard Preferred as a *preferred provider.*

Orthodontic Treatment means the movement of one or more teeth by the use of *active appliances.* It includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

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

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

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

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

Preferred Provider means a *dentist* or dental care facility that is under contract with DentalGuard Preferred as a preferred provider.

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

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

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

Options A, B, C, D, E, F, S, T, U, V, W and X

DISCOUNT - THIS IS NOT INSURANCE

Discounts on Dental Services Not Covered By This Plan

A covered person under this plan can receive discounts on certain services not covered by this plan, as described below, if:

(a) he or she receives services or supplies from a dentist that is under contract with our DentalGuard Preferred Provider Organization (PPO) network; and

(b) the service or supply is on the fee schedule the dentist has agreed to accept as payment in full as a member of the PPO network.

The services described in this provision are not covered by this plan. The covered person must pay the entire discounted fee directly to the dentist. There is no need to file a claim.

When a person is no longer covered by this plan, access to the network discounts ends.

P499.0076

Options A, B, C, D, E, F, S, T, U, V, W and X

Discounts on Services Not Covered Due To Contractual Provisions

If a covered person receives dental services from a dentist who is under contract with Guardian's DentalGuard Preferred PPO, such services will be provided at the discounted fee the dentist agreed to accept as payment in full as a member of our DentalGuard Preferred PPO network, even if such services are not covered by the plan due to:

- Meeting the plan's benefit year payment limit provision;
- Frequency limitations; or
- Plan exclusions, such as dental implants.

P499.0078

Options A, B, S and T

Discounts on Orthodontic Services

If a covered person receives any of the following orthodontic dental services from an orthodontist who is under contract with Guardian's DentalGuard Preferred PPO network, such services will be provided at the discounted fee the dentist has agreed to accept as payment in full as a member of such network. The services are:

- Pre-orthodontic treatment visit
- Limited orthodontic treatment
- Interceptive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits;
- Comprehensive orthodontic treatment, including fabrication and insertion of fixed appliances and periodic visits
- Periodic comprehensive orthodontic treatment visit (as part of a contract);
- Orthodontic retention, including fixed and removable initial appliances and related visits.

Discounted fees are not available for:

- Incremental charges for orthodontic appliances made with clear, ceramic, white, lingual brackets or other optional materials;
- Procedures, appliances or devices to guide minor tooth movement or to correct harmful habits;

- Retreatment of orthodontic cases, or changes in orthodontic treatment needed due to an accident;
- Extractions performed solely to facilitate orthodontic treatment;
- Orthognathic surgery and associated incremental charges;
- Replacement of lost or broken retainers.

P499.0080

All Options

ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

P505.0053

All Options

EMPLOYEE COVERAGE

Eligible Employees

Subject to the Conditions of Eligibility set forth below, and to all of the other conditions of the plan, all of your employees who are in an eligible class will be eligible if they are active full-time employees.

For purposes of this plan, we will treat partners and proprietors like employees if they meet this plan's conditions of eligibility.

Conditions of Eligibility

Full-time Requirement: We won't insure an employee unless he or she is an active full-time employee.

GP-1-EC-90-1.0 P180.0168

All Options

Vision Enrollment Requirement: An employee must enroll and agree to make required payments within 31 days of his or her eligibility date. If he or she fails to do so, he or she can't enroll until this plan's next vision open enrollment period.

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

Once an employee enrolls in this plan, he or she can't drop his or her vision coverage until this plan's next vision open enrollment period. And if he or she drops his or her vision coverage, he or she can't enroll again until the next vision open enrollment period.

If the employee initially waived vision coverage under this plan because he or she was covered for vision care benefits under another group plan, and he or she wishes to enroll in this plan because his or her coverage under the other plan ends, he or she may do so without waiting until the next vision open enrollment period. However, his or her coverage under the other plan must have ended due to one of the following events: (a) termination of a spouse's employment; (b) loss of eligibility under a spouse's plan; (c) divorce; (d) death of a spouse; or (e) termination of the other plan. But the employee must enroll in this plan within 30 days of the date that any of these events occur.

GP-1-EC-90-2.0 P505.0070

All Classes

The Waiting Period: Employees in an eligible class are eligible for insurance under this plan after they complete the service waiting period established by the employer, if any.

GP-1-EC-90-4.0 P180.0936

All Options

Multiple Employment: If an employee works for both you and a covered associated company, or for more than one covered associated company, we will treat him as if only one firm employs him. And such an employee will not have multiple coverage under this plan. But, if this plan uses the amount of an employee's earnings to set the rates, determine class, figure benefit amounts, or for any other reason, such employee's earnings will be figured as the sum of his earnings from all covered employers.

GP-1-EC-90-5.0 P180.0328

All Options for All Classes

When Employee Coverage Starts

An employee must be actively at work, and working his or her regular number of hours, on the date his or her coverage is scheduled to start. And he or she must have met all of the conditions of eligibility which apply to him or her . If an employee is not actively at work on his or her scheduled effective date, we will postpone the start of his or her coverage until he or she returns to active work.

Sometimes, a scheduled effective date is not a regularly scheduled work day. But an employee's coverage will start on that date if he or she was actively at work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The scheduled effective date of an employee's coverage is as follows:

- If an employee must pay part of the cost of employee coverage, then he or she must elect to enroll and agree to make the required payments. If he or she does this on or before the eligibility date, or within 31 days of the eligibility date, his or her coverage is scheduled to start on his or her eligibility date. If he or she does this more than 31 days after his or her eligibility date, his or her coverage is scheduled to start on the date he or she signs his or her enrollment form.
- On non-contributory plans, subject to all the terms of this plan, an employee's coverage is scheduled to start on his or her eligibility date.

GP-1-EC-90-6.0 P505.0605

All Options for All Classes

When Employee Coverage Ends

When Employee Coverage Ends: Except as explained in the "When Active Service Ends" section of this plan, an employee's insurance will end on the first of the following dates:

- the last day of the month in which an employee's active full-time service ends for any reason other than disability. Such reasons include retirement, layoff, leave of absence or the end of employment.
- the date an employee dies.
- the date the group plan ends, or is discontinued for a class of employees to which the employee belongs; or
- the day prior to the last premium due date for which required payments are made for the employee.
- the last day of the month in which an employee stops being an eligible employee under this plan for any reason not named above.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. The plan's benefit provisions explain these situations. Read the plan's provisions carefully.

GP-1-EC-90-8.0 P489.0006

All Options for All Classes

When Active Service Ends: You may continue an employee's vision expense insurance under this plan after his active service with you ends only as follows:

- If an employee's active service ends because he is disabled you may continue his insurance subject to all of the terms of this plan.
- If an employee's active service ends because he goes on a leave of absence or is laid off, you may continue his insurance for the rest of the policy month in which the leave or layoff starts, plus 1 more full policy month(s). However, if the employee joins any armed force before this period ends, you may continue his insurance until the date he becomes a member of such armed force.

- If you continue an employee's benefits under this plan as set forth above, it must be based on a plan which prevents individual selection by you.
- And, any such continuation is subject to the payment of premiums, and to all of the other terms and conditions of this plan.
- The amount of an employee's insurance during any such continuation will be the amount in force on his last day of active service, subject to any reductions that would have otherwise applied if he had remained an active employee.

GP-1-EC-90-7.0 P505.0073

All Options

An Employee's Right To Continue Group Insurance During A Family Leave Of Absence

Important Notice: This section may not apply to your plan. The employee must contact you to find out if you must allow for a leave of absence under federal law. In that case the section applies.

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

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

- The date the employee returns 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 the employee's coverage would have ended had the employee not been on leave.
- The end of the period for which the premium has been paid.

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

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.

- **Contingency Operation:** This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

- **Covered Servicemember:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a), is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin:** This term means the nearest blood relative of the employee.

- **Outpatient Status:** This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness:** This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating,

GP-1-EC-90-7.0 P449.0523

All Options

Definitions

GP-1-EC-90-DEF-1 P180.0155

All Options

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

GP-1-EC-90-DEF-2 P180.0156

All Options

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

GP-1-EC-90-DEF-3 P180.0311

All Options

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

GP-1-EC-90-DEF-4 P180.0158

All Options

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

GP-1-EC-90-DEF-6 P180.0160

All Options

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

GP-1-EC-90-DEF-9 P180.0163

All Options

You and **Your** means the employer who purchased this plan.

GP-1-EC-90-DEF-10 P180.0164

All Options

Dependent Coverage

GP-1-DEP-90-1.0 P200.0305

All Options

Eligible Dependents For Dependent Vision Care Benefits: An employee's eligible dependents are: (a) his or her legal spouse; and (b) his or her dependent children who are under age 26; and who are: (i) dependent upon the employee for support; and (ii) residing with the employee, or enrolled as full-time or part-time students at accredited schools.

A dependent child who is not able to remain enrolled as a 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. The employee 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.

GP-1-DEP-90-2.0 P505.1430

All Options

Adopted Children and Step-Children: An employee's "unmarried dependent children" include his or her legally adopted children and, if they depend on the employee 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 employee's 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.

GP-1-DEP-90-3.0 P264.0005

All Options

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

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

If a claim submitted on behalf of the child is denied because the child has reached the limiting age, the employee must submit proof that: (a) the child's condition started before he or she reached the age limit; (b) the child became insured before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) the child depends on the employee for most of his or her support and maintenance.

The child's coverage ends when the employee's does.

GP-1-DEP-90-4.0 P489.0028

All Options for All Classes

When Dependent Coverage Starts: In order for an employee's dependent coverage to begin, he or she 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 an employee's dependent coverage starts depends on when he or she elect to enroll all of his or her initial dependents and agree to make any required payments.

If the employee does this on or before his or her eligibility date, his or her dependent coverage is scheduled to start on the later of the date he or she signs the enrollment form and the date he or she becomes covered for employee coverage.

If the employee does this during the enrollment period, his or her dependent coverage is scheduled to start on the date the employee becomes insured for employee coverage.

If the employee does this after the enrollment period ends, he or she can't enroll his or her initial dependents until the next vision open enrollment period.

Once the employee has coverage for his or her initial dependents, he or she must notify us when he or she acquires any new dependents, and agree to make any additional payments required for the coverage. If the employee does 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 the employee fails to notify us on time, he or she 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.

GP-1-DEP-90-6.0 P505.0606

All Options

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

GP-1-DEP-90-7.0 P200.0708

All Options

Newborn Children: We cover an employee's newborn child from the moment of birth if the employee is already insured for dependent vision coverage, and he or she notifies us within 31 days of the child's birth. If the employee fails to notify us on time, he or she can't enroll the child until the next vision open enrollment period.

If the newborn child is the employee's first eligible dependent, we cover the child from the moment of birth if the employee enrolls for dependent coverage and agrees to make any required payments within 31 days of the child's birth. If the employee fails to enroll on time, he or she can't enroll the child until the next vision open enrollment period.

If the newborn child is not the employee's first eligible dependent, but the employee did not previously enroll his or her other eligible dependents for vision care expense coverage, the employee can enroll the child during the next vision open enrollment period, if he or she also enrolls all of his or her other eligible dependents at this time.

GP-1-DEP-90-8.0 P505.0068

All Options

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

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

Dependent coverage also ends for all of an employee's dependents when the employee stops 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 an employee is required to pay all or part of the cost of dependent coverage, and he or she fails to do so, his or her dependent coverage ends. It ends on the last day of the period for which he or she made the required payments, unless coverage ends earlier for other reasons.

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

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

GP-1-DEP-90-9.0 P489.0266

All Options

Definitions

GP-1-DEP-90-DEF-1 P200.0210

All Options

Eligibility Date for dependent coverage is the earliest date on which: (a) the employee has dependents; and (b) is eligible for dependent coverage.

GP-1-DEP-90-DEF-2 P200.0211

All Options

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

GP-1-DEP-90-DEF-3 P200.0212

All Options

Enrollment Period means the 31 day period which starts on the date that the employee is eligible for dependent coverage.

GP-1-DEP-90-DEF-4 P200.0213

All Options

Initial Dependents means those eligible dependents the employee has at the time he or she first becomes eligible for employee coverage. If at this time he or she does not have any eligible dependents, but later acquires them, the first eligible dependents he or she acquires are his or her initial dependents.

GP-1-DEP-90-DEF-8 P200.0217

All Options

Newly Acquired Dependent means an eligible dependent the employee acquires after he or she already has coverage in force for initial dependents.

GP-1-DEP-90-DEF-9 P200.0218

All Options

Plan means the Guardian group plan purchased by the employer.

GP-1-DEP-90-DEF-11 P264.0065

All Options

We, Us, Our and **Guardian** means The Guardian Life Insurance Company of America.

GP-1-DEP-90-DEF-14 P200.0223

All Options

You and **Your** means the employer who purchased this plan.

GP-1-DEP-90-DEF-15 P200.0224

Options A, B, C, D, E, F, G and H

ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00533014-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

(herein called the Policyholder)

Effective January 1, 2017, this rider amends the "Dependent Coverage" provision cares 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.

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.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section;

b. continuation of vision care coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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.

Dated at _____ This _____ Day of _____ , ____

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

GP-1-A-DMST-96-FL P505.0086

Options S, T, U, V, W, X, Y and Z

ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00533014-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

(herein called the Policyholder)

Effective June 1, 2017, this rider amends the "Dependent Coverage" provision cares 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.

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.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section;

b. continuation of vision care coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

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.

Dated at _____ This _____ Day of _____ , ____

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

GP-1-A-DMST-96-FL P505.0086

Options B, D, F, H, T, V, X and Z

VISION CARE EXPENSE INSURANCE
>

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

GP-1-VSN-07-VIS-L P505.0518

Options B, D, F, H, T, V, X and Z

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

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, 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.

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.

GP-1-VSN-07-PPOA-L P505.0520

Options B, D, F and H

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 must request approval for Necessary Contact Lenses from VSP.

No benefits will be paid for Necessary Contact Lenses if prior approval is not received from VSP.

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

GP-1-VSN-07-PTR2-L P505.0523

Options T, V, X, Z, B, D, F and H

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 wished 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.

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 Person's 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 or 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

GP-1-VSN-07-APP-L P505.0524

Options T, V, X and Z

HOW THIS PLAN WORKS

We pay benefits for the covered charges a Covered Person incurs as follows. 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.

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.

If a Covered Person plans to use the services of a Preferred Provider, the Preferred Provider must receive pre-authorization 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.

If a Covered Person receives services or supplies from a Non-Preferred Provider, he or she must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 90 days of the date services are completed or supplies are received.

Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include the necessary tests to ensure visual wellness and detect potential eye-related medical problems, such as glaucoma.

We cover no more than one vision examination for each covered person in any calendar year period.

From a Preferred Provider: We pay benefits in full for the covered charges a Covered Person incurs.

From a Non-Preferred Provider: We pay benefits for the covered charges a Covered Person incurs up to a maximum of $39.00 for each examination.

Vision Materials

Glasses (Lenses and Frames) or Contact Lenses: We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or Lenticular Lenses. We pay benefits for frames. We pay benefits for prescription contacts lenses and a contact lens exam needed to check for eye health risks associated with improper wearing or fitting of contact lenses.

In any calendar year period we pay benefits for either glasses or contact lenses, but not both.

Materials Payment Limit: We limit what we pay for covered materials in any calendar year period to an allowance of $50.00. The discounts shown below are applied before the charges are applied to the allowance.

- Materials purchased from either a Preferred Provider or a Non-Preferred Provider are covered by this Plan, and can be used toward the $50.00 allowance.
- If the materials are purchased from a Preferred Provider either more than a calendar year after a covered eye exam, or from a doctor other than the Preferred Provider who performed the exam, the cost of the purchase will not be covered by this plan and cannot be used toward the allowance.
- Charges for only an initial purchase can be used toward the $50.00 allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. For example, if a covered person purchases a pair of glasses for $40.00 the remaining $10.00 of the allowance will be unused. The covered person will have a new $50.00 allowance at the beginning of the calendar year following the date of the purchase.
- Also, if a covered person purchases only frames or lenses (not a complete pair of glasses) the initial purchase will be used toward the allowance and the unused balance will not be banked for future use, even if the covered person purchases the other item later. The covered person will have a new $50.00 allowance starting at the beginning of the calendar year following the date of the purchase.

Discounts on Materials Purchased From a Preferred Provider: For glasses, a covered person will receive a 20% discount off the Preferred Provider's usual and customary fee, if:

- A complete (lenses and frames) pair of glasses is purchased; and
- The purchase is made within 12 months of a covered eye exam, and only from the Preferred Provider who performed the exam

If a covered person purchases either lenses or frames only (not a complete pair of glasses), the discount will not be given. If the glasses are purchased either more than 12 months after a covered eye exam, or from a Preferred Provider other than the one who performed the exam, the discount will not be given.

For non-covered cosmetic lens options such as coated or blended lenses, the Covered Person will receive a 20% discount off the Preferred Provider's usual and customary fee for the additional cost of the cosmetic feature.

For contact lenses, a Covered Person will receive a 15% discount off the Preferred Provider's usual and customary contact lens professional services fees for the contact lens exam, if the purchase is made within 12 months of a covered eye exam, and only from the Preferred Provider who performed the exam. Discounts do not apply to the contact lenses.

GP-1-VSN-09-HPW-L P505.1013

Options B, D, F and H

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.

Services or Supplies From a Preferred Provider

If a Covered Person uses the services of a Preferred Provider, the Preferred Provider must 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:

For each vision examination from a Preferred Provider $10.00

For each pair of Standard Frames and/or Standard Lenses from a Preferred Provider $25.00

For Necessary Contact Lenses from a Preferred Provider $25.00

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 additional 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 Fitting Costs	15% off of the Preferred Provider's Usual and Customary Fee

GP-1-VSN-96-BEN1-L P505.1016

Options B, D, F and H

Services or Supplies From a Non-Preferred Provider

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 180 days of the date services are completed or supplies are received. 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	$10.00
For each pair of Standard Frames and/or Standard Lenses from a Non-Preferred Provider	$25.00
For each pair of Necessary Contact Lenses from a Non-Preferred Provider	$25.00

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%

GP-1-VSN-07-BEN2-L P505.0547

Options B, D, F and H

Covered Charges

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.

Covered Services and Supplies

This section lists the types of charges we cover. But what we pay is subject to all of the terms of this 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.

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.

GP-1-VSN-96-LIST1-L P505.1017

Options B, D, F and H

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.

GP-1-VSN-09-SL-L P505.1024

Options B, D, F and H

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

GP-1-VSN-09-SL-L P505.1045

Options B, D, F and H

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.

GP-1-VSN-09-SF-L P505.1058

Options B, D, F and H

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.

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.

GP-1-VSN-07-LIST7-L P505.1067

Options B, D, F and H

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 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.

GP-1-VSN-09-ECL-L P505.1083

Options B, D, F, H, T, V, X and Z

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.

GP-1-VSN-07-SL1-L P505.0551

Options T, V, X and Z

Exclusions

We won't pay for:

- Orthoptics or vision training and any associated supplemental testing.
- Medical or surgical treatment of the eyes.
- Any eye examination or corrective eyewear required by an employer as a condition of employment.
- Plano lenses.
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.
- Expenses associated with securing materials such as lenses and frames.
- Blended lenses, oversized lenses, or progressive multifocal lenses.
- Coating of lenses, laminating of lenses, cosmetic lenses.
- UV(ultraviolet) protected lenses.
- Photochromatic lenses and tinted lenses, except for Pink #1 and Pink #2.
- Refitting of contact lenses after the initial 90-day fitting period.
- Routine maintenance of contact lenses such as polishing or cleaning.
- Corneal Refractive Therapy(CRT) or Orthokeratology(a procedure using contact lenses to change the shape of the cornea in order to reduce myopia).
- Optional cosmetic processes.

GP-1-VSN-07-XCL1-L P505.0598

Options T, V, X and Z

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.

GP-1-VSN-07-EXC17-L P505.0597

Options B, D, F and H

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.

GP-1-VSN-07-EXC1-L P505.0594

Options B, D, F and H

- 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).

GP-1-VSN-09-EXC P505.0921

Options B, D, F and H

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

P505.0922

Options B, D, F and H

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

P505.0923

Options B, D, F and H

- We will not pay for the scratch resistant coating of the lens or lenses.

P505.0924

Options B, D, F and H

- We will not pay for blended lenses.

P505.0925

Options B, D, F and H

- We will not pay for high index lenses.

P505.0926

Options B, D, F and H

- We will not pay for the mirror/ski coating of the lens or lenses.

P505.0927

Options B, D, F and H

- We will not pay for oversized lenses.

P505.0928

Options B, D, F and H

- We will not pay for laminating of the lens or lenses.

P505.0929

Options B, D, F and H

- We will not pay for edge treatment.

P505.0930

Options B, D, F and H

- We will not pay for progressive lenses.
- We will not pay for progressive multifocal lenses.

P505.0931

Options B, D, F and H

- We will not pay for the anti-reflective coating of the lens or lenses.

P505.0932

Options B, D, F and H

- We will not pay for polycarbonate lenses.

P505.0933

GP-1-VSN-09-EXC-L P505.1085

Options B, D, F and H

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.

GP-1-VSN-07-EXC17-L P505.0597

Options B, D, F, H, T, V, X and Z

Definitions

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

GP-1-VSN-07-DEF1-L P505.0552

Options B, D, F, H, T, V, X and Z

Benefit Period 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.

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

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

Copayment 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.

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.

Customary 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.

Deductible means any amount which a Covered Person must pay before he or she is reimbursed for covered services provided by a Non-Preferred Provider.

Incurred, or **Incurred Date** means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

GP-1-VSN-07-DEF2-L P505.0553

Options B, D, F, H, T, V, X and Z

Keratoconus 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.

Lenticular Lenses 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.

GP-1-VSN-07-DEF3-L P505.0557

Options B, D, F, H, T, V, X and Z

Low Vision is a partial loss of vision. It is a loss of acuity or sharpness or a loss of side vision. Any Low Vision benefits available under this Plan are subject to prior authorization by PPO consultants.

GP-1-VSN-07-DEF5-L P505.0558

Options B, D, F, H, T, V, X and Z

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

GP-1-VSN-07-DEF7-L P505.0560

Options B, D, F, H, T, V, X and Z

Oversize Lenses mean larger than a Standard Lens blank, to accommodate prescriptions.

Photochromic Lenses mean lenses which change color with the intensity of sunlight.

Plan means the Vision Service Plan group policy of vision care services described herein.

Plan Benefits with respect to vision care insurance, mean the vision care services and vision care materials which a Covered Person is entitled to receive by virtue of coverage under this Plan.

Plano Lenses mean lenses which have no refractive power (lenses with less than a .38 diopter power).

Standard Frames mean frames valued up to the limit published by VSP which is given to Preferred Providers.

Standard Lenses mean regular glass or plastic lenses. See the Special Limitations for what we limit or exclude.

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

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.

Visually Necessary or Appropriate means medically or visually necessary to for the restoration or maintenance of a Covered Person's visual acuity and health and for which there is no less expensive professionally acceptable alternative.

GP-1-VSN-07-DEF8-L P505.0561

Options A, C, E, G, S, U, W and Y

VISION CARE BENEFITS

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

GP-1-DAVIS-07-VIS-L P505.0563

Options A, C, E, G, S, U, W and Y

This Plan's Vision Care Preferred Provider Organization

Davis Vision: This plan is designed to provide a high quality vision care benefit 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 Davis Vision's Preferred Provider Network.

This vision care preferred provider organization (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 credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A covered person may receive vision care from either a preferred provider or a non-preferred 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 of 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, frequencies, copayments and payment limits.

The covered person can call Davis Vision if he or she has any questions after reading this material.

Choice of Preferred Providers: When a person becomes enrolled in this plan, he or she will receive information about Davis Vision preferred providers in his or her area. A covered person may receive vision services from any current Davis Vision preferred provider.

When a covered person wants to receive services from a preferred provider, he or she must contact the preferred provider before receiving treatment. The preferred provider will contact Davis Vision to verify the covered person's eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a preferred provider.

Non-Preferred Providers: If a covered person receives services or supplies from a non-preferred provider, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

Claims for services or supplies from a non-preferred provider must be sent to:

Davis Vision - Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

GP-1-DAVIS-07-PPOA-L P505.0565

Options A, C, E, G, S, U, W and Y

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the covered person's vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, covered person or patient may appeal denied authorizations or claim decisions. Should a covered person request a review of an authorization or claim decision, Davis Vision must notify the covered person, or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the covered person or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision's Grievance Resolution process or as per plan contract. A covered person has the right to appeal through an external review organization at any time during the grievance process. A covered person has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the covered person's legal rights.

Grievance Process

Registering a Complaint or Grievance: A covered person has the right to file a grievance or make an appeal to any claim decision at any time. The covered person has the right to designate a representative to file complaints and appeals on his or her behalf.

A covered person is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a covered person should the determination be made that vision care benefits are not available.

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:

1. via the telephone.
2. in writing to Davis Vision.
3. via the Davis Vision Website.

A "grievance" or complaint can arise from and includes but is not limited to the following:

1. benefit denials;
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract;
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services;
4. challenges with vision care services or products received;
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication: A covered person may file a verbal grievance by contacting Davis Vision. Registering a complaint or grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the complaint or appeal is received.

A covered person has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact his or her Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: **1 (800) 584-1487**

Written Grievances: Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

Davis Vision

159 Express Street

Plainview, New York 11803

Attention: Quality Assurance/Patient Advocate Department

A covered person can register any concern or grievance by logging on to Davis' website: www.davisvision.com and entering the "Contact Davis Vision" area.

Internal Grievance Procedure

Appeal Level 1: Upon receipt of a concern or grievance by a Davis Vision associate, the covered person is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the covered person or his or her designated representative. Contact may include, but is not limited to, telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the covered person and may request additional information. Details of the complaint are documented in the covered person's file. The covered person is given the associate's name, phone number, department and the estimated time needed to perform the research. The covered person is informed of his or her right to have a representative, including his or her provider, present during the review of the concern and final outcome of the investigation. The covered person is informed of his or her right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the covered person when further information is required and inform him or her of the status of the investigation or the need for more information.

The determination will be communicated to the covered person within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the covered person within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the covered person appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the covered person to Davis Vision within fifteen (15) business days of the date of notice of the decision.

Options A, C, E, G, S, U, W and Y

Appeal Level 2: Should Davis Vision uphold a denial, as the result of a Level 1 review, The covered person has the right to request a Level 2 appeal.

A Level 2 appeal will not include Associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the covered person to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The covered person requesting a Level 2 appeal must indicate the reason they believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to request further information from the covered person or provider.

Davis Vision has thirty (30) days, or as required by state statue, from the date the requested information is received, to respond to the Level 2 pre-service review. Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination, the covered person will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the covered person appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

External Grievance Procedure

External Review: A covered person, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A covered person who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.

External Review Process: A covered person has the right to an external review of a denial of coverage. A covered person has the right to an external review of a final adverse decision under the following circumstances:

- the covered person has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the covered person has been denied and any alternative service or treatment will not affect the covered person's ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.

- the denied service, procedure or treatment is a covered benefit under the covered person's policy.
- The covered person has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the covered person and the subsequent diagnostic findings could alter the covered person's treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.

GP-1-DAVIS-07-APP-2-L P505.0568

Options A, C, E and G

How This Plan Works

We pay benefits for the covered charges a covered person incurs as follows. 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.

Covered charges are the usual 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.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.

GP-1-DAVIS-07-HPW-L P505.0569

Options S, U, W and Y

How This Plan Works

We pay benefits for the covered charges a covered person incurs as follows. 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.

Covered charges are the usual 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.

GP-1-DAVIS-07-HPW-L P505.0570

Options A, C, E and G

Copays: A covered person must pay a copay each time he or she receives a vision examination. A covered person must pay a copay each time he or she receives any vision materials covered by this plan.

GP-1-DAVIS-07-COP-L P505.0571

Options S, U, W and Y

Copays: A covered person must pay a copay each time he or she receives a vision examination covered by this plan.

GP-1-DAVIS-07-COP-L P505.0574

Options A, C, E and G

How We Cover Vision Examinations: A covered person must pay a $10.00 copay each time he or she receives a vision examination. If the vision examination is performed by a preferred provider, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a non-preferred provider, we pay benefits in excess of the copay up to $50.00.

We pay benefits for one vision examination in any calendar year.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

GP-1-DAVIS-07-VE-L P505.0664

Options S, U, W and Y

How We Cover Vision Examinations: A covered person must pay a none copay each time he or she receives a vision examination. If the vision examination is performed by a preferred provider, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a non-preferred provider, we pay benefits in excess of the copay up to $46.00.

We pay benefits for one vision examination in any 12 month period.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;

- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

GP-1-DAVIS-07-VE-L P505.0575

Options A, C, E and G

How We Cover Vision Materials: We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or lenticular lenses. We pay benefits for frames. We pay benefits for prescription contact lenses.

In any calendar year, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any period of 2 calendar years, we pay benefits for one set of frames.

GP-1-DAVIS-07-VM-L P505.0679

Options S, U, W and Y

How We Cover Vision Materials: We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or lenticular lenses. We pay benefits for frames. We pay benefits for prescription contact lenses and a contact lens exam needed to check for eye health risks associated with improper wearing or fitting of contacts.

GP-1-DAVIS-07-VM-L P505.0578

Options S, U, W and Y

Materials Payment Limit: We limit what we pay for covered materials in any 12 month period to a $50.00 allowance. The discounts shown below are applied before the charges are applied to the allowance.

- Materials purchased from either a preferred provider or a non-preferred provider are covered by this plan, and can be used toward the $50.00 allowance.
- Charges only for an initial purchase can be used toward the $50.00 allowance. Any unused balance remaining after the initial purchase cannot be banked for future use. For example, if a covered person purchases glasses for $40.00, the remaining $10.00 of the allowance will be unused. The covered person will have a new $50.00 allowance starting 12 months from the date of the purchase.
- Also, if a covered person purchases only frames or lenses (not a complete set of glasses) the initial purchase will be used toward the allowance and the unused balance will not be banked for future use, even if the covered person purchases the other item later. The covered person will have a new $50.00 allowance starting 12 months from the date of the purchase.

GP-1-DAVIS-07-MPL-L P505.0579

Options S, U, W and Y

Discounts on Materials Purchased From a Preferred Provider*: If a covered person receives the following materials from a preferred provider, the covered person will receive the following discounts off the retail price.

For frames:

- for frames that cost up to $70 retail, the covered person must pay $40.
- for frames that cost over $70 retail, the covered person must pay $40 and will receive 10% off the amount over the $70 retail price.

For standard lenses:

- for single vision lenses, the covered person must pay $35.00.

- for bifocal lenses, the covered person must pay $55.00.
- for trifocal lenses, the covered person must pay $65.00.
- for lenticular lenses, the covered person must pay $110.00.

For cosmetic extras, the following additional copayment will be added to those above.

- for standard progressive lenses, the covered person must pay $75.00.
- for premium progressive lenses, the covered person must pay $125.00.
- for glass lenses, the covered person must pay $18.00.
- for polycarbonate lenses, the covered person must pay $30.00.
- for blended invisible bifocals, the covered person must pay $20.00.
- for intermediate vision lenses, the covered person must pay $30.00.
- for scratch resistant coating, the covered person must pay $20.00.
- for standard anti-reflective coating, the covered person must pay $45.00.
- for ultraviolet coating, the covered person must pay $15.00.
- for solid tint, the covered person must pay $10.00.
- for gradient tint, the covered person must pay $12.00.
- for photogrey, the covered person must pay $35.00.
- for plastic photosensitive, the covered person must pay $65.00.
- for high index lenses, the covered person must pay $55.00.
- for polarized lenses, the covered person must pay $75.00.

For Contact Lenses:

- contact lens examination 15% off usual and customary charges
- conventional contact lenses at 20% off retail price
- for disposable contact lenses at 10% off retail price
- free membership in Lens123 mail order replacement contact lens program.

Discounts on Other Products -

Laser Vision Correction - Up to 25% off usual and customary when performed by a Preferred Provider

* At Wal-Mart locations, members will receive Wal-Mart's every day low price on frame and contact lens purchases.

GP-1-DAVIS-07-DOM-L P505.0581

Options A, C, E and G

How We Cover Standard Lenses: A covered person must pay a $25.00 copay each time he or she purchases standard lenses. If the lenses are received from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a non-preferred provider, we pay benefits in excess of the copay up to:

- $48.00 for single vision lenses;
- $67.00 for bifocal lenses;
- $86.00 for trifocal lenses; and
- $126.00 for lenticular lenses.

We cover one pair of standard lenses in any calendar year.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras;

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses (for children up to age 20 and monocular I individuals and Covered Persons with prescriptions of greater than +/-6.00 diopters);
- glass-grey #3 prescription sunglasses.

The following cosmetic lens extras are not covered. But if a covered person purchases his or her lenses from a preferred provider, the price will be discounted as follows:

- standard progressive addition lenses - $50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - $90
- photochromatic lenses - single vision or multifocal - $20
- scratch resistant coating - single vision or multifocal - $20
- ultra violet coating - $12
- blended invisible bifocal lenses - $20
- intermediate Lenses - $30
- plastic photosensitive lenses - $65
- polarized lenses - $75
- hi-Index lenses - $55
- supershield (scratchguard) coating - $20
- glare resistant treatment (multi layer hydrophobic) - $35
- premium glare resistant treatment - $48

GP-1-DAVIS-07-SL-L P505.0688

Options A, C, E and G

How We Cover Elective Contact Lenses: We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of standard lenses and frames.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses and frames until the next following calendar year.

A covered person must pay a $25.00 copay each time he or she purchases elective contact lenses.

If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $105.00.

If the contact lenses are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis' elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a $25.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of $130.00. The copay is waived.
- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of a pair of non-formulary elective contact lenses, including evaluation and fitting, from the same preferred provider*.

The discount is an amount equal to 15% of the preferred provider's usual and customary fee in excess of the copay and retail elective contact lenses allowance.

*At Wal-Mart locations, covered persons will receive Wal-Mart's every day low price on purchases of elective contact lenses.

We cover one pair of elective contact lenses in any calendar year.

GP-1-DAVIS-07-ECL-L P505.0698

Options A, C, E and G

How We Cover Necessary Contact Lenses: We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of keratoconus; and
- the covered person complies with the following requirements regarding prior notification.

The covered person or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of keratoconus before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A covered person must pay a $25.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $210.00.

GP-1-DAVIS-07-NCL-L P505.0585

Options A, C, E and G

How We Cover Frames: A covered person must pay a copay each time he or she purchases a set of frames.

If the frames are purchased from a non-preferred provider, we pay benefits in excess of a $25.00 copay up to $48.00.

If the frames are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis' Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a $25.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a $50.00 copay.
- We cover a non-Tower frame in excess of a $25.00 copay up to the retail frame allowance of $130.00.
- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of purchasing a pair of non-Tower frames from the same preferred provider*.

  The discount is an amount equal to 20% of the preferred provider's usual and customary fee in excess of the copay and retail frame allowance.

  *At Wal-Mart locations, covered persons will receive Wal-Mart's every day low price on frame purchases.

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

GP-1-DAVIS-07-FRM-L P505.0720

Options A, C, E, G, S, U, W and Y

Exclusions

- We won't pay for orthoptics or vision training and any associated supplemental training.
- 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.
- We won't pay for plano lenses (lenses with less than a +/-.38 diopter power).
- We won't pay for two sets of glasses in lieu of bifocals.
- We won't 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 won't pay for necessary contact lenses prescribed for a covered person affected with keratoconus for which prior notification was not sent to Davis Vision.
- We won't pay for lens cosmetic extras that are not specifically listed in this Plan as covered.

GP-1-DAVIS-07-EXC-L P505.0588

Options A, C, E, G, S, U, W and Y

DEFINITIONS

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

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

"Copay" means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a covered person before any benefits are paid by this plan.

"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.

"Customary" means, when referring to a covered charge, that the charge for the covered vision condition is not more than the usual charge made by most other doctors with similar training and experience in the same geographic area.

"Keratoconus" means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

"Lenticular Lenses" means 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.

"Non-Preferred Provider" with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the covered persons of the plan. "Orthoptics" means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

"Oversize Lenses" means larger than a standard lens blank to accommodate prescriptions.

"Photochromic Lenses" means lenses which change color with the intensity of sunlight.

"Plan" means the Davis Vision group policy of vision care services described herein.

"Plano Lenses" means lenses which have no refractive power (lenses with less than a .38 diopter power).

"Preferred Provider" with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of covered persons of the plan.

"Standard Lenses" means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

"Tinted Lenses" means lenses which have an additional substance added to produce constant tint.

"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.

GP-1-DAVIS-07-DEF-L P505.0590

Options A, B, C, D, E, F, S, T, U, V, W and X

ATTACHED TO AND MADE PART OF GROUP INSURANCE POLICY NO. G -00533014-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

(herein called the Policyholder)

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of the any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follow when titanium or high noble metal (gold) is used in a *dental prosthesis.*

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

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

Dated at _____ This _____ Day of _____ , ____

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

GP-1-A-DGOPT-10 P531.0025

Options A, B, C, D, E, F, S, T, U, V, W and X

COORDINATION OF BENEFITS

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

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

Definitions

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

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

(1) The amount a benefit is reduced by the primary plan because a person does not comply with the plan's provisions is **not** an allowable expense. Examples of these provisions are preferred provider arrangements.

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

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

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

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

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

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

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

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

Plan: This term means any of the following that provides benefits or services for dental care or treatment: (1) group hospital, medical or surgical expense insurance; (2) group health care services plans; (3) group-type self-insurance plans; and (4) governmental benefits, as permitted by law.

This term does not include: (a) individual or family insurance; (b) school accident type coverage; (c) indemnity-type policies, excess insurance coverage, health benefit policies limiting coverage to specified illnesses or accidents; or (d) Medicare, Medicare supplement policies, Medicaid, and coverage under other governmental plans, unless permitted by law.

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

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

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

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

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

Order Of Benefit Determination

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

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

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

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

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

Options A, B, C, D, E, F, S, T, U, V, W and X

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

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

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

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

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

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

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

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

Effect On The Benefits Of This Plan

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

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

Right To Receive And Release Needed Information

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

Facility Of Payment

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

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

Right Of Recovery

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

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

GP-1-R-COB-05 P555.0280

Options A, B, C, D, E, F, S, T, U, V, W and X

ATTACHED TO AND MADE A PART OF GROUP INSURANCE POLICY NO. G-00533014-

issued by

The Guardian Life Insurance Company of America

(herein called the Insurance Company)

to

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

(herein called the Policyholder)

As of January 1, 2017, this plan is amended, as explained below, with respect to any of this plan's provisions.

As used in this rider:

"Covered Person" means an employee or dependent, including the legal representative of a minor or incompetent, insured by this plan.

"Reasonable pro-rata Expenses" are those costs, such as lawyers fees and court costs, incurred to effect a third party payment, expressed as a percentage of such payment.

"Third Party" means anyone other than The Guardian, the employer or the covered person.

We will not pay any benefits under this plan, to or on behalf of a covered person, who has received payment in whole or in part from a third party, or its insurer for past or future medical or dental charges or loss of earnings, resulting from the negligence, intentional act, or no-fault tort liability of a third party.

If a covered person makes a claim to us for medical, dental or loss of earnings benefits under this plan prior to receiving payment from a third party or its insurer, the covered person must agree, in writing, to repay us from any amount of money they receive from the third party, or its insurer.

The repayment will be equal to the amount of benefits paid by us. However, the covered person may deduct the reasonable pro-rata expenses, incurred in effecting the third party payment, from the repayment to us.

The repayment agreement will be binding upon the covered person whether: (a) the payment received from the third party, or its insurer, is the result of a legal judgement, an arbitration award, a compromise settlement, or any other arrangement; or (b) the third party, or its insurer, has admitted liability for the payment; or (c) the medical or dental charges or loss of earnings are itemized in the third party payment.

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

Dated at _____ This _____ Day of _____ , ____

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

GP-1-TPL-90 P600.0003

All Options

STATEMENT OF ERISA RIGHTS

As a participant, an employee is 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 The 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 the employee, his or her spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. The employee and his or her dependents may have to pay for such coverage. The employee should review the summary plan description and the documents governing the plan on the rules governing his or her 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 the employer, an employee's union, or any other person may fire an employee or otherwise discriminate against him or her in any way to prevent the employee from obtaining a welfare benefit or exercising his or her rights under ERISA.

Enforcement Of An Employee's Rights

If an employee's claim for a welfare benefit is denied or ignored, in whole or in part, he or she has 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 an employee can take to enforce the above rights. For instance, if an employee requests a copy of plan documents or the latest annual report from the plan and does not receive them within 30 days, he or she 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 the employee up to $110.00 a day until he or she receives the material, unless the materials were not sent because of reasons beyond the control of the administrator. If an employee has a claim for benefits which is denied or ignored, in whole or in part, he or she may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if an employee is discriminated against for asserting his or her rights, the employee may seek assistance from the U.S. Department of Labor, or he or she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If an employee is successful, the court may order the person he or she sued to pay these costs and fees. If the employee loses, the court may order him or her to pay these costs and fees, for example, if it finds that the employee's claim is frivolous.

Assistance with Questions

If an employee has questions about the plan, he or she should contact the plan administrator. If an employee has questions about this statement or about his or her rights under ERISA, or if the employee needs assistance in obtaining documents from the plan administrator, he or she should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. An employee may also obtain certain publications about his or her 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 an employee has questions about this statement, he or she should see the plan administrator.

P800.0066

All Options

The Guardian's Responsibilities

P800.0037

Options A, B, C, D, E, F, S, T, U, V, W and X

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

P800.0041

All Options

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.

P800.0043

All Options

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

P800.0038

GROUP HEALTH BENEFITS CLAIMS PROCEDURE

If an employee seeks benefits under the plan he or she 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 an employee's claim.

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

Definitions

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

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

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

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

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

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

Timing For Initial Benefit Determination

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determinations

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

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

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

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

In reviewing an appeal, Guardian will

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

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

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

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

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

Alternative Dispute Options

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

P800.0056

This part of your plan is your Managed DentalGuard dental care expense insurance policy.

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

Options G, H, Y and Z

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA

7 Hanover Square, New York, New York 10004

GROUP BENEFIT PLAN
FOR DENTAL CARE EXPENSES

Planholder: PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC

Group Plan Number: G-00533014

Delivered in: Florida

Plan Effective Date: January 1, 2017

Plan Anniversaries: January 1st of each year, beginning in 2018.

The Guardian (referred to in this Plan as "The Guardian," "us," "we," or "our"), in consideration of the application for this Plan and of the payment of premiums as stated herein, agrees to provide benefits in accordance with and subject to the terms of this Plan. **THIS IS A PREPAID LIMITED HEALTH SERVICE PLAN LICENSED UNDER FLORIDA LAW.**

Premiums are payable by the Planholder as hereinafter provided. The first premium is due on the Plan Effective Date, and subsequent premiums are due, during the continuance of this Plan, the first day of each month.

This Plan is delivered in the jurisdiction specified above and is governed by the laws thereof.

The provisions set forth on the following pages are part of this Plan.

This Plan takes effect on the Plan Effective Date specified above, and terminates on the last day of the month one year later if not renewed.

In Witness whereof, The Guardian has caused this Plan to be executed as of May 12, 2017 which is its date of issue.

The Guardian Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

GP-1-MDG-FL-1-08 P850.0843

Options G, H, Y and Z

Premium Rates

The monthly premium rates, in U.S. dollars, for the insurance provided under this Policy are as follows:

Options G, H, Y and Z Class 0001

Rate per Employee	per Employee and Insured Spouse with no Insured Child	per Employee and Insured Child(ren) with no Insured Spouse	per Employee and Insured Family
$ 10.46	$ 20.72	$ 29.23	$ 40.34

We have the right to change any premium rate(s) set forth at the times and in the manner established by the provisions contained in this Policy entitled "Premiums" and "Adjustment of Premiums."

Options G, H, Y and Z

GENERAL PROVISIONS

Effective Date

This Policy shall be effective on the Policy Effective Date shown on the face page of this Policy and shall continue until the last day of the month in which the termination of this Policy occurs. All coverage under the Policy shall begin and end at 12:01 A.M., Eastern Standard Time.

Premium Payments

The first premium payment for this Policy is due on the Policy Effective Date. Further payments shall be made on the first day of each month for each month this plan is in effect. The Policyholder shall pay The Guardian the total sum indicated for each eligible Member. The Guardian may change such rates on the first day of any month. The Guardian must give the Policyholder 31 days written notice of the rate change. Such change will apply to any premium due on or after the effective date of the change stated in such notice.

Limitation Of Authority

No agent is authorized to alter or amend this Policy, 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 Policy 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 Policyholder and by one of the aforesaid officers of The Guardian.

Entire Contract

This Policy, including any amendments thereto and application, constitutes the entire agreement of the parties. This Policy may only be modified by a writing executed by the parties.

GP-1-MDG3 P850.0044

Options G, H, Y and Z

Disputes Between Parties

Any dispute, grievance or controversy arising between the Policyholder and The Guardian, or between a Member and The Guardian, involving this Policy, any of its terms and conditions, its breach or non-performance may be settled, if both parties agree, by arbitration pursuant to the rules and regulations then in force and effect of the Florida Arbitration Code, Chapter 682 of the Florida statutes. The arbitration shall take place in Florida and judgment upon any award rendered by the arbitrator may be duly entered in any court in the State of Florida having jurisdiction thereof. The prevailing party shall be entitled to court costs and reasonable attorney's fees.

GP-1-MDGFL4 P850.0045

Options G, H, Y and Z

Notice

Whenever it shall become necessary for either party to serve notice on the other with respect to this Policy, such notice shall be in writing and shall be served by certified mail, return receipt requested, addressed as follows:

If to a Policyholder: At the Policyholder's most current address on file with The Guardian (It is the Policyholder's responsibility to timely notify The Guardian of address changes.)

If to The Guardian: The Guardian Life Insurance Company of America 7 Hanover Square New York, New York 10004

Conformity With Statutes

This policy shall be governed by the laws of the State of Florida.

Unenforceability, Invalidity Or Waiver Or Any Violation Of Any Provision Of The Policy

If any provision of this Policy is held to be illegal or invalid for any reason, such decision shall not affect the validity of the remaining provisions of this Policy and such remaining provisions shall continue in full force and effect unless the illegality or invalidity prevent the accomplishment of the objectives and purposes of this Policy.

Compliance With Erisa

In the event the Policyholder is regulated under the Employee Retirement Income Security Act of 1974 (ERISA), the Policyholder agrees that it and not The Guardian shall be responsible for meeting all requirements of ERISA. The Guardian will cooperate with the Policyholder in supplying the Policyholder with any information within its possession to aid the Policyholder in meeting any ERISA reporting requirements. The Guardian is not and shall not be designated the administrator or fiduciary of the Plan.

Non-Assignability

This Policy is non-assignable by either party without consent of the other party. The Guardian may, in its sole discretion, delegate administration functions to other entities. Any attempt to make such an assignment shall be void and may result, at The Guardian's option, in the termination of a Member's coverage.

Options G, H, Y and Z

Incontestability

This Policy 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 Member may be used in contesting the validity of his or her coverage or denying a claim for a loss incurred, after such insurance has been in force for two years during his or her lifetime.

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

Associated Companies

If the Policyholder asks us in writing to include an associated company under this Policy and we give our written approval, we'll treat employees of that company like the Policyholder's employees. Our written approval will include the starting date of the company's coverage under this Policy. Each eligible employee of that company must still meet all of the terms and conditions of this Policy before he or she will be enrolled in the plan.

The Policyholder must notify us in writing when a company stops being associated with it. On the date a company stops being an associated company, this Policy will end for all of that company's employees, except those employed by the Policyholder or another covered associated company as eligible employees on such date.

Clerical Error - Misstatements

Neither clerical error by the Policyholder or The Guardian in keeping any records pertaining to insurance under this Policy, nor delays in making entries thereon, will invalidate coverage otherwise in force or continue coverage otherwise validly terminated. Upon discovery of such error or delay, an equitable adjustment of premiums will be made.

If the age of a Member, or any other relevant facts, are found to have been misstated, and the premiums are thereby affected, an equitable adjustment of fees will be made. If such misstatement involves whether or not an insurance risk would have been accepted by us, or the amount of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Policy, and in what amount.

Statements

No statement will void the coverage under this Policy, or be used in defense of any claim hereunder unless: (a) in the case of the Policyholder, it is contained in the application signed by him or her ; or (b) in the case of a Member is contained in a written instrument signed by him or her.

All statements will be deemed representations and not warranties.

Employee's Certificate

We will issue to the Policyholder, for delivery to each employee covered under this Policy, a certificate of coverage. The certificate will state the essential features of the coverage to which the employee is entitled and to whom the benefits are payable. The certificate does not constitute a part of this Policy and will in no way modify any of the terms and conditions set forth in this Policy.

In the event this Policy is amended, and such amendment affects the material contained in the Certificate of Coverage, a rider or revised Certificate reflecting such amendment will be issued to the Policyholder for delivery to affected employees.

GP-1-MDG6 P850.0047

Options G, H, Y and Z

Claims Of Creditors

Except when prohibited by the laws of the jurisdiction in which this Policy was issued, the coverage under this Policy will be exempt from execution, garnishment, attachment or other legal or equitable process, for the debts or liabilities of the covered persons or their beneficiaries.

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 Policy as often as we feel necessary. We'll pay for all such examinations.

Premiums

The Policyholder shall pay The Guardian the total sum indicated in the "Premium Rates" section of this Policy, per Member per month, commencing on the Policy effective date shown on the face page of this Policy. Payment shall be made on the first day of the month for each month this Policy is in effect. Premiums due under this Policy must be paid by the Policyholder at an office of The Guardian or to a representative that we have authorized.

The Policyholder shall arrange to collect any necessary Member contributions toward the premiums from the Members and pay the total premium on behalf of those Members. The Policyholder agrees that it shall act as the agent for its Members and not, under any circumstances, as an agent, employee or representative of The Guardian in collecting any amount from such Members and paying it to The Guardian. The initial premium is set forth on the application. The premium is paid by The Policyholder, unless other provisions for payment are agreed to in advance by The Guardian.

Adjustment Of Premiums

The premiums due under this Policy on each due date will be the sum of each premium per Member covered by this Policy.

We may change such premiums: (a) on the first day of each policy month; (b) on any date to the extent or terms of services provided to a Policyholder are changed by amendment to this Policy; (c) on any date our obligation under this Policy with respect to a Policyholder is changed because of statutory or other regulatory requirements; (d) if this Policy supplements or coordinates with benefits provided by any other insurer, non-profit hospital or medical service plan or health or dental maintenance organization, on any date our obligation under this Policy is changed because of a change in such other benefits. We will provide the Policyholder with 30 days advance written notice of any premium changes.

Grace Period - Termination Of Policy

A grace period of 31 days, without interest charge, will be granted to the Policyholder for each premium except the first. If any premium is not paid before the end of the grace period, this Policy automatically terminates on the last day of the month to which the grace period applies. The Policyholder will still owe us premiums for the month this Policy was in effect during the grace period.

Renewal Of Policy

The Guardian and the Policyholder may renew this Policy at the end of the term thereof, and by mutual consent modify or alter this Policy, provided that said modifications, amendments, alterations or renewals shall be in writing, duly executed by both parties hereto and attached to this Policy.

Records - Information To Be Furnished

The Policyholder shall keep a record of Employees insured containing, for each Employee, the essential particulars of coverage. The Policyholder shall, as prescribed by The Guardian, periodically forward to The Guardian on Guardian's forms such information concerning the Employees eligible for coverage under this Policy as may reasonably be considered to have a bearing on the administration of the coverage under this Policy, the determination of premiums and any other information which The Guardian may reasonably require.

Options G, H, Y and Z

MEMBER ELIGIBILITY AND TERMINATION PROVISIONS

Enrollment Procedures: Eligible Employees may enroll for dental coverage by: (a) filling out and signing an enrollment form and any additional material You may require during any open enrollment period; and (b) returning the enrollment material to You. You will forward these materials to Guardian.

The enrollment materials require the selection of a Primary Care Dentist (PCD) for each Member. After the enrollment material has been received by Guardian, We will determine if a Member's selected PCD is available in this Plan. If so, the selected dentist will be assigned to the Member as his or her PCD. If a Member's selection is not available, an alternate Dentist will be assigned as the PCD. A Member need only contact his or her assigned PCD's office to obtain services.

Guardian will issue each Member, either directly or through Your representative, a Guardian MDG ID card. The ID card will show the Member's name and the name and telephone number of his or her assigned PCD.

You will send a copy of the billing/eligibility list to Guardian by the 15th day of the current month. The list will: (a) state any changes to the current listing of Members to be covered for that month; and (b) specifically identify the data which follows:

1. Members newly eligible to receive services;
2. Members who are no longer eligible to receive services;
3. Whether an Employee's coverage is single or includes Dependents; and
4. Members' social security numbers or other identification numbers.

Open Enrollment Period: If the Employee does not enroll for dental coverage under this Plan within 30 days of becoming eligible, he or she must wait until the next open enrollment period to enroll. The open enrollment period is a 30-day period which occurs once every 12 months after this Plan's effective date, or at time intervals mutually agreed upon by You and Guardian.

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

If, after initial enrollment, a Member disenrolls from the Plan before the open enrollment period, he or she may not re-enroll until the next open enrollment period which occurs after the Member has been without coverage for 1 full year.

Changes in Member Status: If a Member is terminated or is no longer employed by You: (a) he or she shall continue to be eligible to receive services and (b) Guardian shall be entitled to its monthly premium until (i) such time that the Member is removed from the eligibility list described above and (ii) the last day of the month in which you notify Guardian in writing of the member's termination. However, (ii) does not apply:

1. When this Plan ends or the employee terminates coverage under this Plan but remains eligible;
2. When the employee ceases to be eligible within 7 days of the end of the month and we receive notice from You within the first 3 business days of the next month;
3. If You notify us at least 30 days prior to the date an employee is no longer eligible under this Plan;
4. When an employee elects to end coverage under this Plan and obtains other coverage which takes effect after termination of eligibility under this Plan and prior to the end of coverage under this Plan;
5. If the employee is covered under a federal or state continuation of coverage requirement that allows the employee to pay premium and extend coverage under this Plan after he or she leaves employment or is no longer eligible;
6. When the entire premium for this coverage is paid by the covered employee; or
7. After the date of the employee's death or the date the employee receives the last covered service under this Plan.

Also, an employee may have the right to continue certain group benefits for a limited time after his or her coverage would otherwise end. The Plan's benefit provisions explain these situations. Read the Plan's provisions carefully.

SHOULD GUARDIAN BE NOTIFIED OF A MEMBER'S TERMINATION AFTER THE 20TH DAY OF THE MONTH FOLLOWING THE MONTH OF TERMINATION, GUARDIAN WILL RETAIN OR MUST BE PAID THE PREMIUM FOR THE MONTH IN WHICH THE MEMBER'S TERMINATION WAS REPORTED.

When Coverage Starts: Coverage starts on the date shown on the face page of this Plan for all Members enrolled on or before the Plan effective date. Coverage for a new Member starts on: (a) the first day of the month following the date enrollment materials were received by Guardian; or (b) the first day of the month after the end of any waiting period You may require.

When Dependent Coverage Starts: Except as stated below, Dependents shall be eligible for coverage on the later of: (a) the date the Employee is eligible for coverage; or (b) the first day of the month following the date on which the Employee acquires such Dependent.

If the Dependent is a newborn child, his or her coverage begins on the date of birth. If the Dependent is: (a) a stepchild; or (b) a foster child, coverage begins on the date that child begins to reside in the home. If the Dependent is an adopted child, coverage begins on the date that the child is subject to a legal suit for adoption. If a newborn child, adopted child or foster child becomes covered under this Plan, the Employee must complete enrollment materials for such 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.

When Coverage Ends: Subject to any continuation of coverage privilege which may be available to a Member, a Member's coverage under this Plan ends when the Planholder's coverage terminates. Provided that Guardian receives notification as provided in the above section, "Changes in Member Status", a Member's coverage also ends on the first to occur of:

1. The end of the period for which the last premium payment is made for a Member;
2. The end of the month in which the Member is no longer eligible for coverage under this Plan;
3. The end of the month in which a Dependent is no longer a Dependent as defined in this Plan;
4. The date on which the Member no longer resides or works in the Service Area;
5. The end of the month during which You receive written notice from the Member requesting termination of coverage, or on such later date as requested by the notice;
6. The date of entry of a Member into active military duty. But, coverage will not end if the Member's duty is temporary. Temporary duty is duty of 31 days or less;
7. 30 days after Guardian sends written notice to a Member advising that his or her coverage will end because the Member has: (a) knowingly given false information in writing on his or her enrollment form; or (b) misused his or her ID card or other documents provided to obtain benefits under this Plan; or (c) otherwise acted in an unlawful or fraudulent manner regarding Plan services and benefits; or 8.

30 days after Guardian sends written notice to a Member, where Guardian has: (a) addressed the failure of the Member and his or her PCD to establish a satisfactory patient-dentist relationship; (b) offered the Member the opportunity to select another PCD; and (c) described the changes necessary to avoid termination.

Extended Dental Expense Benefits: If a Member's coverage ends, We extend dental expense benefits for him or her under this Plan as explained below.

Benefits for orthodontic services end at the termination of the Member's coverage under this Plan. We extend benefits for covered services other than orthodontic services only if the procedure(s) are: (a) started before the Member's coverage ends; and (b) are completed within 90 days after the date his or her coverage ends. Inlays, onlays, crowns and bridges are started when the tooth or teeth are prepared. Dentures are started when the impressions are taken. Root canal is started when the pulp chamber is opened.

The extension of benefits ends on the first to occur of: (a) 90 days after the Member's coverage ends; or (b) the date he or she becomes covered under another plan which provides coverage for similar dental procedures. But, if the plan which succeeds this Plan excludes the above services through the use of an elimination period, then the extension of benefits will end 90 days after the Member's coverage ends.

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

GP-1-MDG-FL-ELIG-A-08 P850.0844

Options G, H, Y and Z

CONTINUATION OF COVERAGE

The Members are eligible to retain coverage under this Policy during any Continuation of Coverage period or election period, necessary for the Policyholder'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 a Member, provided the Policyholder continues to certify the eligibility of the Member and the monthly premiums for COBRA coverage for Members continue to be paid by or through the Policyholder pursuant to this Policy.

An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to this Policy. The Member must contact the Policyholder to find out if:

(a) the Policyholder is subject to the "Federal Continuation Rights" section, and therefore;

(b) the section applies to the Member.

Federal Continuation Rights

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

This section applies to dental benefits. 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 dental benefits under this Policy as: (a) an active, covered Employee of the Policyholder; or (b) the Dependent of an active, covered Employee. Any person who becomes covered under this Plan during a continuation provided by this section is not a qualified continuee.

If An Employee's Group Dental Benefits End: If an Employee's group dental benefits end due to termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months if: (a) he or she was not terminated due to gross misconduct; (b) he or she is not covered for benefits from any other group plan at the time his or her group dental benefits under this Plan would otherwise end; and (c) he or she is not entitled to Medicare.

The continuation: (a) may cover the Employee 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 the Employee's termination of employment or reduction of work hours, he or she may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.

To elect the extra 11 months of continuation, the qualified continuee must give You 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 You 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 Employee by You during this extra 11 month continuation period.

If An Employee Dies While Insured: If an Employee dies 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 An Employee's Marriage Ends: If an Employee's 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 Policy, other than Employee's 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 the Employee's 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) the Employee becomes 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 You, in writing, of: (a) the legal divorce or legal separation of the Employee from his or her spouse; or (b) the loss of Dependent eligibility, as defined in this Policy, of a Dependent.

Such notice must be given to You within 60 days of either of these events.

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

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

Your Liability: You will be liable for the qualified continuee's continued group dental benefits to the same extent as, and in place of, us if: (a) You fail 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) You fail to notify the qualified continuee of his or her continuation rights, as described above.

Options G, H, Y and Z

Election Of Continuation: To continue his or her group dental benefits, the qualified continuee must give You 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 You 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 You, by the qualified continuee, in advance, at the times and in the manner specified by You. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group dental benefits had the qualified continuee stayed enrolled in the group plan on a regular basis. It includes any amount that would have been paid by You. 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 You.

If the qualified continuee fails to give You 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 Employee's 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;

(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 dental 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 Employee's death, the Employee's 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 the Employee's 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 Policy 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.

Options G, H, Y and Z

DENTAL BENEFITS PLAN

This Plan will cover many of a Member's dental expenses. MDG decides: (a) the requirements for benefits to be paid; and (b) what benefits are to be paid by this Plan. We also interpret how this Plan is to be administered. What we cover and the terms of coverage are explained below.

Managed DentalGuard - This Plan's Dental Coverage Organization

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 the Managed DentalGuard network (MDG network). The MDG network is made up of Participating Dentists in the plan's approved Service 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 current MDG Participating General Dentists. Each Member must be assigned to a Primary Care Dentist (PCD) from this list of Participating General Dentists. This PCD will coordinate all of the Member's dental care covered by this Plan. After enrollment, a Member will receive a Guardian MDG ID card. A Member must present this ID card when he or she goes to his or her PCD.

What we cover is based on all the terms of this Plan. Read this Plan carefully for: specific benefit levels, payment rates, payment limits, conditions, exclusions and limitations and Patient Charges.

Members may call the MDG Member Services Department if they have any questions after reading this Plan.

Choice Of Dentists: A Member may request any available Participating General Dentist as his or her PCD. A request to change a PCD must be made to Guardian. Any such change will be effective the first day of the month following approval; however, 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 PCD must be paid in full prior to such a transfer.

Right to Reassign Member: Guardian reserves the right to reassign Members to a different Participating Dentist in the event that either: (a) the Member's Dentist is no longer a Participating Dentist in the MDG network; or (b) MDG takes an administrative action which impacts the Dentist's participation in the network. Guardian will notify the Member of the dentist's network status change in writing as soon as reasonably possible. If this becomes necessary, the Member will have the opportunity to request another Participating Dentist. If a Member has a dental service in progress at the time of the reassignment, Guardian will, in its discretion and subject to applicable law, either: (a) arrange for completion of the service by the original dentist; or (b) make reasonable and appropriate arrangements for another Participating Dentist to complete the service.

Refusal of Recommended Treatment: A Member may decide to refuse a course of treatment recommended by his or her *PCD* or specialty care dentist. The Member can request and receive a second opinion by contacting Member Services. If the Member still refuses the recommended course of treatment, the *PCD* or specialty care dentist may have no further responsibility to provide services for the condition involved and the Member may be required to select another *PCD* or specialty care dentist.

If Guardian Fails To Pay Participating Dentist: In the event Guardian fails to pay a Participating Dentist, the Member shall not be liable to the Participating Dentist for any sums owed by Guardian.

Relationship Between You And Participating Dentists And Institutions: You understand that: (a) the operation and maintenance of the participating dental offices, facilities and equipment; and (b) the rendition of all dental services are under the control and supervision of a Participating Dentist. The Participating Dentist has all authority and control over: (a) the selection of staff; (b) the supervision of personnel and operation of the professional practice; and/or (c) the rendering of any particular service or treatment.

Guardian will undertake to see that the services provided to Members by Participating Dentists will be performed in accordance with professional standards prevailing in the county in which each Participating Dentist practices. Guardian compensates its Participating General Dentists through a capitation agreement by which they are paid a fixed amount each month. The amount a Participating General Dentist is paid is based upon the number of Members who have the Dentist assigned as their PCD. MDG may also make minimum monthly payments, supplemental payments on specific dental procedures, office visit payments and annual guarantee payments. These are the only forms of compensation a Participating General Dentist receives from Guardian. The Dentist also receives compensation from Members who may pay an office visit charge for each office visit and a Patient Charge for specific dental services. The schedule of Patient Charges is shown in the Covered Dental Services and Patient Charge section of this Plan.

Options G, H, Y and Z

Specialty Care Referrals: A Member's PCD is responsible for providing all covered services. But, certain services may be eligible for referral to a Participating Specialty Care Dentist. Guardian will pay for covered services for specialty care, less any applicable Patient Charges, when such covered services are provided in accordance with the specialty referral process described below.

Guardian compensates its Participating Specialty Care Dentists the difference between their contracted fee and the Patient Charge shown in the Covered Dental Services And Patient Charges section. This is the only form of compensation that Participating Specialty Care Dentists receive from Guardian.

ALL SPECIALTY CARE REFERRAL SERVICES MUST BE: (A) PRE-AUTHORIZED BY GUARDIAN; AND (B) COORDINATED BY A MEMBER'S PCD. ANY MEMBER WHO ELECTS SPECIALTY CARE SERVICES WITHOUT PRIOR REFERRAL BY HIS OR HER PCD AND APPROVAL BY GUARDIAN IS RESPONSIBLE FOR ALL CHARGES INCURRED.

In order for specialty care services to be covered by this Plan, the specialty referral process stated below must be followed:

(1) A Member's PCD must coordinate all dental care.

(2) When the care of a Participating Specialty Care Dentist is required, the Member's PCD must contact Guardian and request authorization.

(3) If the PCD's request for specialty care referral is approved, the Member will be notified by Guardian and instructed to contact the Participating Specialty Care Dentist to schedule an appointment.

(4) If the PCD's request for specialty referral is denied as not medically necessary (an adverse determination), the PCD and the Member will receive a written notice along with information on how to appeal the denial to an independent review organization. (See Appeal of Adverse Determination, below, under Complaint and Appeal Procedures.)

(5) If the service in question: (a) is a covered service; and (b) no exclusions or limitations apply to that service, the PCD may be asked to perform the service directly, or to provide more information.

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

(7) A Member who receives authorized specialty services is responsible for all applicable Patient Charges for the services provided.

When specialty dental care is authorized by Guardian, a Member will be referred to a Participating Specialty Care Dentist for treatment. The MDG network includes Participating Specialty Care Dentists in: (a) oral surgery; (b) periodontics; (c) endodontics; (d) orthodontics; and (e) pediatric dentistry, located in the Plan's approved Service Area. If there is no Participating Specialty Care Dentist in the Plan's approved Service Area, Guardian will refer the Member to a Non-Participating Specialty Care Dentist of Guardian's choice. In no event

will Guardian pay for dental care provided to a Member by a Specialty Care Dentist not pre-authorized by Guardian to provide such services.

GP-1-MDG-FL-10-B-08 P850.0847

Options G, H, Y and Z

Emergency Dental Services: We provide for Emergency Dental Services 24 hours a day, 7 days a week, to all Members. A Member should contact his or her selected and assigned PCD, who will make arrangements for such care. If the Member is unable to reach his or her PCD in an emergency during normal business hours, he or she must contact Our Member Services Department for instructions. If the Member is not able to reach his or her PCD in an emergency after normal business hours, the Member may seek Emergency Dental Services from any Dentist. Then, within 2 business day, he or she should call Guardian to advise of the emergency claim. The Member must submit to Guardian: (a) the bill incurred as a result of the emergency; (b) evidence of payment; (c) a brief explanation of the emergency; and (d) a description of the attempts to reach his or her PCD. This must be done within 90 days, or as soon as is reasonably possible. We will reimburse the Member for 50% of the cost of the Emergency Dental Services.

Out-Of-Area Emergency Dental Services: If a Member is more than 50 miles from his or her home and Emergency Dental Services are required, he or she may seek care from any Dentist. Then he or she must file a claim within 90 days, or as soon as is reasonably possible. He or she must present an acceptable detailed statement from the treating Dentist. The statement must list all services provided. We will reimburse the Member within 30 days for any covered Emergency Dental Services, up to a maximum of $50.00 per incident, after payment of any Patient Charge which may apply.

GP-1-MDG-FL-EM-08 P850.0848

Options G, H, Y and Z

Grievance Process: There are three stages to the grievance process: (a) the Informal Internal Grievance Process; (b) the Formal Internal Grievance Review Process for standard and expedited reviews; and (c) the External Review.

As used in this section:

"Adverse determination" means a decision by Guardian to deny, reduce or end coverage for: (a) availability of care; or (b) any other dental care services. This decision is made because the service or supply does not meet all the terms of the plan based on: (a) medical necessity; (b) appropriateness; (c) health care setting; (d) level of care; or (e) effectiveness. This decision is based on the review of the information given to Guardian.

"Agency" means the Agency for Health Care Administration of the State of Florida.

"Clinical peer" means a dental care professional in the same or similar specialty who typically manages the medical condition, procedure or treatment under review. But, it does not mean a person who was involved in the initial adverse determination.

"Complaint" means any expression of dissatisfaction by a member that relates to the quality of care given by a provider pursuant to Guardian's contract with that provider. It:

(a) includes dissatisfaction with: (i) the administration; (ii) claims practices; or (iii) provision of services;

(b) may be made to Guardian or to a state agency; and

(c) is part of the informal steps of a grievance process.

"Concurrent review" means a utilization review conducted during a course of treatment.

"Grievance" means a written complaint submitted to Guardian or a state agency by or on behalf of a member regarding these items:

(a) availability, coverage for the delivery, or quality of dental care services, and includes an adverse

determination made pursuant to utilization review;

(b) claims payment, handling, or reimbursement for dental care services; or

(c) matters pertaining to the contractual relationship between a member and Guardian.

"Retrospective review" means a review, for coverage purposes, of medical necessity conducted after services have been provided to a patient.

"Urgent grievance" means a grievance where using the standard timeframe of the grievance process would: (a) seriously jeopardize the life or health of a member; or (b) would jeopardize the member's ability to regain maximum function.

"Working day" means Monday through Friday from 9 a.m. to 9 p.m. Eastern Time. It does not include legal holidays.

Informal Internal Grievance Process A member may make a complaint to Guardian at this address or phone number.

Managed Dental Guard
Quality of Care Liaison
PO Box 4391
Woodland Hills CA 91365
1-888-618-2016

When Guardian receives the initial oral complaint, Guardian will respond to the member or the person acting on his or her behalf within a reasonable time. At the time the complaint is received, Guardian will inform the person making the complaint that he or she:

1. has the right to file a written grievance to the address shown above at any time during the complaint process.
2. must submit the written grievance within one year after the date of the action that caused the grievance.
3. may request Guardian's help in preparing the written grievance.
4. has the right to request an external review to the Statewide Provider and Subscriber Assistance Program panel established by the State of Florida. This may be done after the member has received a final adverse determination through Guardian's internal grievance process. The address and toll free phone number are:

   Statewide Provider and Subscriber Assistance Program (SPSAP)
   2727 Mahan Drive, Ft. Knox #1
   Suite 339
   Tallahassee FL 32308
   1-888-419-3456

5. has the right, at any time, to inform the Florida Agency for Health Care Administration (the agency) of the grievance at this address or toll free phone number:

   Statewide Provider and Subscriber Assistance Program (SPSAP)
   2727 Mahan Drive, Ft. Knox #1
   Suite 339
   Tallahassee FL 32308
   1-888-419-3456

Formal Internal Grievance Review Process

Standard Review: If a member, or a person acting on his or her behalf, disagrees or is not satisfied with an adverse determination, he or she may request a review of the grievance by an internal review panel. The request must be made within 30 days after Guardian sends the notice of adverse determination.

The majority of persons on the panel will be providers with appropriate expertise. If there has been a denial of coverage of service, the reviewing provider cannot be the same provider who was involved in the initial adverse determination. The panel may have a person who was previously involved in the adverse

determination appear before the panel to give information or to answer questions. Review procedures established by Guardian are available to the member or the provider acting on behalf of the member. Guardian will give the member and the provider, if the provider filed the grievance, a copy of the panel's written decision. The panel has the right to bind Guardian to its decision.

If the internal review process does not resolve the difference of opinion, the member or the provider acting on behalf of the member, may submit a written grievance to the Statewide Provider and Subscriber Assistance Program.

Guardian will resolve a grievance within 60 days of receipt. But if the grievance involves the collection of material outside the service area: (a) the time limit will be 90 days; and (b) if Guardian notifies the member in writing that such information is needed, the time limit is interrupted until the information is received.

Expedited Review: For an urgent grievance, a member, the member's legal representative, or the provider acting on behalf of the member may request an expedited review. The request may be made orally or in writing. Expedited reviews will be made by appropriate clinical peer(s) who were not involved in the initial adverse determination.

Within 24 hours of receiving a request, Guardian will provide reasonable access to a clinical peer who can perform the expedited review.

Guardian will give all necessary information to the member, or the person acting on his or her behalf, by: (a) telephone; (b) fax; or (c) the most expeditious method available. This includes the decision.

Guardian must make a decision and notify the member, or the person acting on his or her behalf. This must be done as soon as possible but not more that 72 hours after receipt of the request. If the initial notice is not in writing, Guardian will provide a written confirmation of that notice within two working days from the initial notice.

If the expedited review is a concurrent review, the service will be continued without liability to the member until the member has received notice of the decision.

Guardian will not provide an expedited retrospective review of an adverse determination.

Right to Notify the State: A member may submit a copy of the grievance to the agency at any time during the internal grievance review process.

Right to an External Review: The final decision letter for a formal grievance review will notify the member of his or her right to an external review by the Statewide Provider and Subscriber Assistance Program, as explained below.

External Review If a member is not satisfied with the final decision of the formal internal review, he or she may request an external review of that decision by the Statewide Provider and Subscriber Assistance Program. The request for an external review must be made within 365 days after receipt of the final decision letter. It may be made by contacting:

Statewide Provider and Subscriber Assistance Program (SPSAP)
2727 Mahan Drive, Ft. Knox #1
Suite 339
Tallahassee FL 32308
1-888-419-3456

Options G, H, Y and Z

Covered Dental Services and Patient Charges - Plan - U20 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 assigned *PCD.*

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

The *patient charges* listed in this section are only valid for covered services that are: (1) started and completed under this *plan,* and (2) rendered by *participating dentists* in the State of Florida.

CDT Code	Covered Services and Patient Charges U20 M Current Dental Terminology (CDT) (c) American Dental Association (ADA)	Patient Charge
D0999	Office visit during regular hours, general dentist only	$5.00
	EVALUATIONS	
D0120	Periodic oral evaluation - established patient	$0.00
D0140	Limited oral evaluation - problem focused	$0.00
D0145	Oral Evaluation for a patient under 3 years of age and counseling with primary caregiver	$0.00
D0150	Comprehensive oral evaluation - new or established patient	$0.00
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	$0.00
D0180	Comprehensive periodontal evaluation - new or established patient	$0.00
	RADIOGRAPHS/DIAGNOSTIC IMAGING (INCLUDING INTERPRETATION)	
D0210	Intraoral - complete series (including bitewings)	$0.00
D0220	Intraoral - periapical - first film	$0.00
D0230	Intraoral - periapical - each additional film	$0.00
D0240	Intraoral - occlusal film	$0.00
D0270	Bitewing - single film	$0.00
D0272	Bitewings - 2 films	$0.00
D0273	Bitewings - 3 films	$0.00
D0274	Bitewings - 4 films	$0.00
D0277	Vertical bitewings - 7 to 8 films	$0.00
D0330	Panoramic film	$0.00
	TESTS AND EXAMINATIONS	
D0431	Adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	$50.00
D0460	Pulp vitality tests	$0.00
D0470	Diagnostic casts	$0.00
	DENTAL PROPHYLAXIS	
D1110	Prophylaxis - adult, for the first two services in any 12-month period [1, 2]	$0.00
D1120	Prophylaxis - child, for the first two services in any 12-month period [1, 2]	$0.00
D1999	Prophylaxis - adult or child, for each additional service in same 12-month period [1, 2]	$60.00

	TOPICAL FLUORIDE TREATMENT (OFFICE PROCEDURE)	
D1203	Topical application of fluoride (prophylaxis not included) - child, for the first two services in any 12-month period [1, 3]	$0.00
D1204	Topical application of fluoride (prophylaxis not included) - adult, for the first two services in any 12-month period [1, 3]	$0.00
D1206	Topical fluoride (prophylaxis not included) - child, for the first two services in any 12-month period [1, 3]	$12.00
D2999	Topical fluoride, adult or child, for each additional service in same 12-month period [1, 3]	$20.00
	OTHER PREVENTIVE SERVICES	
D1310	Nutritional instruction for control of dental disease	$0.00
D1330	Oral hygiene instructions	$0.00
D1351	Sealant - per tooth (molars) [4]	$8.00
D9999	Sealant - per tooth (non-molars) [4]	$35.00
	SPACE MAINTENACE (PASSIVE APPLIANCES)	
D1510	Space maintainer - fixed - unilateral	$59.00
D1515	Space maintainer - fixed - bilateral	$78.00
D1525	Space maintainer - removable - bilateral	$78.00
D1550	Re-cementation of fixed space maintainer	$13.00
D1555	Removal of fixed space maintainer	$20.00
	ALMALGAM RESTORATIONS (INCLUDING POLISHING)	
D2140	Amalgam - 1 surface, primary or permanent	$20.00
D2150	Amalgam - 2 surfaces, primary or permanent	$27.00
D2160	Amalgam - 3 surfaces, primary or permanent	$32.00
D2161	Amalgam - 4 or more surfaces, primary or permanent	$40.00
	RESIN-BASED COMPOSITE RESTORATIONS - DIRECT	
D2330	Resin-based composite - 1 surface, anterior	$25.00
D2331	Resin-based composite - 2 surfaces, anterior	$30.00
D2332	Resin-based composite - 3 surfaces, anterior	$41.00
D2335	Resin-based composite - 4 or more surfaces or involving incisal angle, (anterior)	$46.00
D2390	Resin-based composite crown, anterior	$57.00
D2391	Resin-based composite - 1 surface, posterior	$30.00
D2392	Resin-based composite - 2 surfaces, posterior	$40.00
D2393	Resin-based composite - 3 or more surfaces, posterior	$47.00
D2394	Resin-based composite - 4 or more surfaces, posterior	$57.00
Options G, H, Y and Z		
	INLAY/ONLAY RESTORATIONS [6]	
D2510	Inlay - metallic - 1 surface [5]	$326.00
D2520	Inlay - metallic - 2 surfaces [5]	$368.00
D2530	Inlay - metallic - 3 or more surfaces [5]	$383.00
D2542	Onlay - metallic - 2 surfaces [5]	$383.00
D2543	Onlay - metallic - 3 surfaces [5]	$400.00
D2544	Onlay - metallic - 4 or more surfaces [5]	$420.00
D2610	Inlay - porcelain/ceramic - 1 surface	$326.00
D2620	Inlay - porcelain/ceramic - 2 surfaces	$368.00
D2630	Inlay - porcelain/ceramic - 3 or more surfaces	$383.00
D2642	Onlay - porcelain/ceramic - 2 surfaces	$383.00
D2643	Onlay - porcelain/ceramic - 3 surfaces	$400.00
D2644	Onlay - porcelain/ceramic - 4 or more surfaces	$420.00

	CROWNS - SINGLE RESTORATIONS ONLY [6]	
D2740	Crown - porcelain/ceramic substrate	$450.00
D2750	Crown - porcelain fused to high noble metal [5]	$430.00
D2751	Crown - porcelain fused to predominantly base metal	$430.00
D2752	Crown - porcelain fused to noble metal	$430.00
D2780	Crown - 3/4 cast high noble metal [5]	$420.00
D2781	Crown - 3/4 cast predominantly base metal	$420.00
D2782	Crown - 3/4 cast noble metal	$420.00
D2783	Crown - 3/4 porcelain/ceramic	$420.00
D2790	Crown - full cast high noble metal [5]	$430.00
D2791	Crown - full cast predominantly base metal	$430.00
D2792	Crown - full cast noble metal	$430.00
D2794	Crown - titanium	$430.00
	OTHER RESTORATIVE SERVICES	
D2910	Recement inlay, onlay, or partial coverage restoration	$16.00
D2915	Recement cast or prefabricated post and core	$16.00
D2920	Recement crown	$16.00
D2930	Prefabricated stainless steel crown - primary tooth	$110.00
D2931	Prefabricated stainless steel crown - permanent tooth	$125.00
D2932	Prefabricated resin crown	$132.00
D2933	Prefabricated stainless steel crown with resin window	$132.00
D2934	Prefabricated esthetic coated stainless steel crown - primary tooth	$142.00
D2940	Sedative filling	$16.00
D2950	Core buildup, including any pins	$113.00
D2951	Pin retention - per tooth, in addition to restoration	$24.00
D2952	Post & core in addition to crown, indirectly fabricated	$160.00
D2953	Each additional indirectly fabricated post - same tooth	$50.00
D2954	Prefabricated post and core in addition to crown	$130.00
D2957	Each additional prefabricated post - same tooth	$29.00
D2960	Labial veneer (resin laminate) - chairside	$250.00
D2970	Temporary crown (fractured tooth)	$100.00
D2971	Additional procedures to construct new crown under existing partial denture framework	$125.00
	PULP CAPPING	
D3110	Pulp cap - direct (excluding restoration)	$12.00
D3120	Pulp cap - indirect (excluding restoration)	$9.00
	PULPOTOMY	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$33.00
D3221	Pulpal debridement, primary and permanent teeth	$32.00
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$33.00
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$37.00
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$38.00
	ENDODONTIC THERAPY (INCLUDING TREATMENT PLAN, CLINICAL PROCEDURES AND FOLLOW-UP CARE)	
D3310	Root canal, anterior (excluding final restoration)	$126.00
D3320	Root canal, bicuspid (excluding final restoration)	$148.00
D3330	Root canal, molar (excluding final restoration)	$192.00

D3331	Treatment of root canal obstruction; non-surgical access	$0.00
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$126.00
D3333	Internal root repair or perforation defects	$63.00
	ENDODONTIC RETREATMENT	
D3346	Retreatment of previous root canal therapy - anterior	$285.00
D3347	Retreatment of previous root canal therapy - bicuspid	$335.00
D3348	Retreatment of previous root canal therapy - molar	$400.00
	APICOECTOMY/PERIRADICULAR SERVICES	
D3410	Apicoectomy/periradicular surgery - anterior	$137.00
D3421	Apicoectomy/periradicular surgery - bicuspid (first root)	$147.00
D3425	Apicoectomy/periradicular surgery - molar (first root)	$155.00
D3426	Apicoectomy/periradicular surgery (each additional root)	$63.00
D3430	Retrograde filling - per root	$46.00
D3950	Canal preparation and fitting of preformed dowel or post	$20.00
	SURGICAL SERVICES (INCLUDING USUAL POSTOPERATIVE CARE)	
D4210	Gingivectomy or gingivoplasty - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$105.00
D4211	Gingivectomy or gingivoplasty - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$30.00
D4240	Gingival flap procedure - including root planing - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$121.00
D4241	Gingival flap procedure, including root planing - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$73.00
D4249	Clinical crown lengthening - hard tissue	$147.00
D4260	Osseous surgery (including flap entry and closure) - 4 or more contiguous teeth or bounded teeth spaces per quadrant	$210.00
D4261	Osseous surgery (including flap entry and closure) - 1 to 3 contiguous teeth or bounded teeth spaces per quadrant	$137.00
D4268	Surgical revision procedure, per tooth	$0.00
D4270	Pedicle soft tissue graft procedure	$147.00
D4271	Free soft tissue graft procedure (including donor site surgery)	$170.00
D4273	Subepithelial connective tissue graft procedures, per tooth	$187.00
	NON-SURGICAL PERIODONTAL SERVICE	
D4341	Periodontal scaling and root planing - 4 or more teeth per quadrant	$42.00
D4342	Periodontal scaling and root planing - 1 to 3 teeth per quadrant	$25.00
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$27.00
	OTHER PERIODONTAL SERVICES	
D4910	Periodontal maintenance, for the first two services in any 12-month period [1, 2]	$28.00
D4920	Unscheduled dressing change (by someone other than treating dentist)	$25.00
D4999	Periodontal maintenance, for each additional service in same 12-month period [1, 2]	$60.00

Options G, H, Y and Z

	COMPLETE DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5110	Complete denture - maxillary	$580.00
D5120	Complete denture - mandibular	$580.00
D5130	Immediate denture - maxillary	$620.00
D5140	Immediate denture - mandibular	$620.00
	PARTIAL DENTURES (INCLUDING ROUTINE POST-DELIVERY CARE)	
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$580.00
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$580.00
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$620.00
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth	$620.00
D5225	Maxillary partial denture - flexible base (including any clasps, rests and teeth)	$675.00
D5226	Mandibular partial denture - flexible base (including any clasps, rests and teeth)	$675.00
	ADJUSTMENTS TO DENTURES	
D5410	Adjust complete denture - maxillary	$27.00
D5411	Adjust complete denture - mandibular	$27.00
D5421	Adjust partial denture - maxillary	$27.00
D5422	Adjust partial denture - mandibular	$27.00
	REPAIRS TO COMPLETE DENTURES	
D5510	Repair broken complete denture base	$69.00
D5520	Replace missing or broken teeth - complete denture (each tooth)	$66.00
	REPAIRS TO PARTIAL DENTURES	
D5610	Repair resin denture base	$80.00
D5620	Repair cast framework	$80.00
D5630	Repair or replace broken clasp	$96.00
D5640	Replace broken teeth - per tooth	$62.00
D5650	Add tooth to existing partial denture	$81.00
D5660	Add clasp to existing partial denture	$102.00
D5670	Replace all teeth and acrylic on case metal framework (maxillary)	$223.00
D5671	Replace all teeth and acrylic on case metal framework (mandibular)	$223.00
	DENTURE REBASE PROCEDURES	
D5710	Rebase complete maxillary denture	$230.00
D5711	Rebase complete mandibular denture	$230.00
D5720	Rebase maxillary partial denture	$230.00
D5721	Rebase mandibular partial denture	$230.00
	DENTURE RELINE PROCEDURES	
D5730	Reline complete maxillary denture (chairside)	$130.00
D5731	Reline complete mandibular denture (chairside)	$130.00

D5740	Reline maxillary partial denture (chairside)	$125.00
D5741	Reline mandibular partial denture (chairside)	$125.00
D5750	Reline complete maxillary denture (laboratory)	$186.00
D5751	Reline complete mandibular denture (laboratory)	$186.00
D5760	Reline maxillary partial denture (laboratory)	$186.00
D5761	Reline mandibular partial denture (laboratory)	$186.00
	INTERIM PROSTHESIS	
D5820	Interim partial denture (maxillary)	$175.00
D5821	Interim partial denture (mandibular)	$175.00
	OTHER REMOVABLE PROSTHETIC SERVICES	
D5850	Tissue conditioning, maxillary	$55.00
D5851	Tissue conditioning, mandibular	$55.00
	FIXED PARTIAL DENTURE PONTICS [6]	
D6210	Pontic - cast high noble metal [5]	$400.00
D6211	Pontic - cast predomniantly base metal	$400.00
D6212	Pontic - cast noble metal	$400.00
D6214	Pontic - titanium	$400.00
D6240	Pontic - porcelain fused to high noble metal [5]	$400.00
D6241	Pontic - porcelain fused to predominantly base metal	$400.00
D6242	Pontic - porcelain fused to noble metal	$400.00
D6245	Pontic - porcelain/ceramic	$410.00
	FIXED PARTIAL DENTURE RETAINERS - INLAYS/ONLAYS [6]	
D6600	Inlay - porcelain/ceramic, - 2 surface	$368.00
D6601	Inlay - porcelain/ceramic, - 3 or more surfaces	$383.00
D6602	Inlay - cast high noble metal, - 2 surfaces [5]	$368.00
D6603	Inlay - cast high noble metal, - 3 or more surfaces [5]	$383.00
D6604	Inlay - cast predominantly base metal, - 2 surfaces	$368.00
D6605	Inlay - cast predominantly base metal, - 3 or more surfaces	$383.00
D6606	Inlay - cast noble metal, 2 surfaces	$368.00
D6607	Inlay - cast noble metal, 3 or more surfaces	$383.00
D6608	Onlay - porcelain/ceramic, 2 surfaces	$383.00
D6609	Onlay - porcelain/ceramic, 3 or more surfaces	$400.00
D6610	Onlay - cast high noble metal, 2 surfaces [5]	$383.00
D6611	Onlay - cast high noble metal, 3 or more surfaces [5]	$400.00
D6612	Onlay - cast predominantly base metal, 2 surfaces	$383.00
D6613	Onlay - cast predominantly base metal, 3 or more surfaces	$400.00
D6614	Onlay - cast noble metal, 2 surfaces	$383.00
D6615	Onlay - cast noble metal, 3 or more surfaces	$400.00
D6624	Inlay - titanium	$368.00
D6634	Onlay - titanium	$383.00
	FIXED PARTIAL DENTURE RETAINERS - CROWNS [6]	
D6740	Crown - porcelain/ceramic	$450.00
D6750	Crown - porcelain fused to high noble metal [5]	$430.00
D6751	Crown - porcelain fused to predominantly base metal	$430.00
D6752	Crown - porcelain fused to noble metal	$430.00
D6780	Crown - 3/4 cast high noble metal [5]	$430.00
D6781	Crown - 3/4 cast predominantly base metal	$430.00
D6782	Crown - 3/4 cast noble metal	$430.00
D6783	Crown - 3/4 porcelain/ceramic	$430.00
D6790	Crown - full cast high noble metal [5]	$430.00
D6791	Crown - full cast predominantly base metal	$430.00
D6792	Crown - full cast noble metal	$430.00

D6794	Crown - titanium	$430.00
	OTHER FIXED PARTIAL DENTURE SERVICES	
D6930	Recement fixed partial denture	$26.00
D6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	$160.00
D6972	Prefabricated post and core in addition to fixed partial denture retainer	$130.00
D6973	Core buildup for retainer, including any pins	$113.00
D6976	Each additional cast post - same tooth	$50.00
D6977	Each additional prefabricated post - same tooth	$29.00
D6999	Multiple crown and bridge unit treatment plan - per unit, 6 or more units per treatment [6]	$125.00
Options G, H, Y and Z		
	EXTRACTIONS	
D7111	Extraction, coronal remnants - deciduous tooth	$16.00
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$23.00
	SURGICAL EXTRACTIONS (INCLUDES LOCAL ANESTHESIA, SUTURING, IF NEEDED, AND ROUTINE POSTOPERATIVE CARE)	
D7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$46.00
D7220	Removal of impacted tooth - soft tissue	$62.00
D7230	Removal of impacted tooth - partially bony	$82.00
D7240	Removal of impacted tooth - completely bony	$96.00
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$116.00
D7250	Surgical removal of residual tooth roots (cutting procedure)	$51.00
D7261	Primary closure of a sinus perforation	$250.00
	OTHER SURGICAL PROCEDURES	
D7280	Surgical access of an unerupted tooth	$82.00
D7283	Placement of device to facilitate eruption of impacted tooth	$35.00
D7285	Biopsy of oral tissue - hard (bone, tooth)	$70.00
D7286	Biopsy of oral tissue - soft	$65.00
D7288	Brush biopsy - transepithelial sample collection	$65.00
	ALEVEOPLASTY - SURGICAL PREPARATION OF RIDGE FOR DENTURES	
D7310	Alveoplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant	$53.00
D7311	Alevoplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant	$26.00
D7320	Alveoplasty not in conjunction with extractions - per quadrant	$92.00
D7321	Alveoplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces	$65.00
	SURGICAL EXCISION OF INTRA-OSSEOUS LESIONS	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$165.00
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$240.00

	EXCISION OF BONE TISSUE	
D7471	Removal of lateral exostosis (maxilla or mandible)	$215.00
D7472	Removal of torus palatinus	$215.00
D7473	Removal of torus mandibularis	$215.00
	SURGICAL INCISION	
D7510	Incision and drainage of abscess - intraoral soft tissue	$44.00
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$48.00
	OTHER REPAIR PROCEDURES	
D7960	Frenulectomy (frenectomy or frenotomy) - separate procedure	$100.00
D7963	Frenuloplasty	$168.00
	UNCLASSIFIED TREATMENT	
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$20.00
D9120	Fixed partial denture sectioning	$15.00
D9215	Local anesthesia	$0.00
D9220	Deep sedation/general anesthesia - first 30 minutes [7]	$195.00
D9221	Deep sedation/general anesthesia - each additional 15 minutes [7]	$75.00
D9241	Intravenous conscious sedation/analgesia - first 30 minutes [7]	$195.00
D9242	Intravenous conscious sedation/analgesia - each additional 15 minutes [7]	$75.00
	PROFESSIONAL CONSULTATION	
D9310	Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)	$34.00
	PROFESSIONAL VISITS	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$0.00
D9440	Office visit - after regularly scheduled hours	$50.00
D9450	Case presentation, detailed and extensive treatment planning	$0.00
	MISCELLANEOUS SERVICES	
D9951	Occlusal adjustment - limited	$23.00
D9971	Odontoplasty, 1-2 teeth	$23.00
D9972	External bleaching - per arch	$165.00
	Broken Appointment	$25.00

[1] The Patient Charges for codes D1110, D1120, D1203, D1204, D1206 and D4910 are limited to the first two services in any 12 month period. For each additional services in the same 12 month period, see codes D1999, D2999 or D4999 for the applicable patient charge.

[2] Routine prophylaxis or periodontal maintenance procedure - One of the two covered periodontal maintenance procedures may be performed by a participating Specialty Care Periodontist if done within three to six months following completion of approved, active periodontal therapy by a participating Specialty Care Periodontist. Active periodontal therapy includes periodontal scaling and root planning or periodontal osseous surgery.

[3] Fluoride treatment - a total of 4 services in any 12 month period.

[4] Sealants are limited to permanent teeth up to the 16th birthday.

[5] If high noble metal is used, there will be an additional patient charge for the actual cost of the high noble metal.

[6] The Patient Charge for these services is per unit.

[7] Procedure codes D9220, D9221, D9241 and D9242 are limited to a participating Specialty Care Oral Surgeon. Additionally, these services are only covered in conjunction with other covered surgical services.

Options G, H, Y and Z

Covered Dental Services And Patient Charges - Plan U20 M

CDT Code	Covered Services and Patient Charges U20 M Current Dental Terminology (CDT) (c) American Dental Association (ADA)	Patient Charge
	ORTHODONTICS [8, 10]	
D8070	Comprehensive orthodontic treatment of the transitional dentition [9, 11]	Child: $2500.00
D8080	Comprehensive orthodontic treatment of the adolescent dentition [9, 11]	Child: $2500.00
D8090	Comprehensive orthodontic treatment of the adult dentition [9, 11]	Adult: $2800.00
D8660	Pre-orthodontic treatment visit (includes treatment plan, records, evaluation and consultation)	$250.00
D8670	Periodic orthodontic treatment visit	$0.00
D8680	Orthodontic retention	$400.00
	Broken Appointment	$25.00

[8] The orthodontic Patient Charges are valid for authorized services started and completed under this Plan and rendered by a Participating Orthodontic Specialty Care Dentist in the state of Florida.

[9] Child orthodontics is limited to dependent children under age 19; adult orthodontics is limited to dependent children age 19 and above, employee or spouse. A Member's age is determined on the date of banding.

[10] Limited to one course of comprehensive orthodontic treatment per Member.

[11] Comprehensive orthodontic treatment is limited to 24 months of continuous treatment.

Options G, H, Y and Z

General Guidelines For Alternative Procedures: There may be a number of accepted methods of treating a specific dental condition. When a *member* selects an *alternative procedure* over the service recommended by the *PCD,* the *member* must pay the difference between the *PCD's* usual charges for the recommended service and the *alternative procedure.* He or she will also have to pay the applicable *patient charge* for the recommended service.

When the *member* selects a posterior composite restoration as an alternative procedure to a recommended amalgam restoration, the *alternative procedure* policy does not apply.

When the *member* selects an extraction, the *alternative procedure* policy does not apply.

When the *PCD* recommends a crown, the *alternative procedure* policy does not apply, regardless of the type of crown placed. The type of crown includes, but is not limited to: (a) a full metal crown; (b) a porcelain fused to metal crown; or (c) a porcelain crown. The *member* must pay the applicable *patient charge* for the crown actually placed.

The *plan* provides for the use of noble, high noble and base metals for inlays, onlays, crowns and fixed bridges. When high noble metal is used, *you* will pay an additional amount for the actual cost of the high noble metal. In addition, *you* will pay the usual *patient charge* for the inlay, onlay, crown or fixed bridge. The total *patient charges* for high noble metal may not exceed the actual lab bill for the service.

In all cases when there is more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *Member* with a treatment *plan* in writing before treatment begins, to assure that there is no confusion over what he or she must pay.

General Guidelines For Alternative Treatment By The PCD: There may be a number of accepted methods for treating a specific dental condition. In all cases where there is more than one course of treatment available, a full disclosure of all the options must be given to the *member* before treatment begins. The *PCD* should present the *member* with a written treatment plan, including treatment costs, before treatment begins, to minimize the potential for confusion over what the *member* should pay, and to fully document informed consent.

If any of the recommended alternate services are selected by the *member* and not covered under the *plan,* then the *member* must pay the *PCD's* usual charge for the recommended alternate service.

If any treatment is specifically not recommended by the *PCD* (i.e., the *PCD* determines it is not an appropriate service for the condition being treated), then the *PCD* is not obliged to provide that treatment even if it is a covered service under the *plan.*

Members can request and receive a second opinion by contacting Member Services in the event they have questions regarding the recommendations of the *PCD or Specialty Care Dentist.*

Crowns, Bridges And Dentures: A crown is a covered service when it is recommended by the *PCD.* The replacement of a crown or bridge is not covered within 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 reline, rebase or repair. Construction of new dentures may not exceed one each in any 5-year period from the date of previous placement under the *plan.* Immediate dentures are not subject to the 5-year limitation.

The benefit for complete dentures includes all usual post-delivery care including adjustments for 6 months after insertion. The benefit for immediate dentures: (a) includes limited follow-up care only for 6 months; and (b) does not include required future permanent rebasing or relining procedures or a complete new denture.

Porcelain crowns and/or porcelain fused to metal crowns are covered on anterior, bicuspid and molar teeth when recommended by the *PCD.*

Multiple Crown and Bridge Unit Treatment Fee: When a *member's* treatment plan includes 6 or more covered units of crown and/or bridge to restore teeth or replace missing teeth, the *member* will be responsible for the *patient charge* for each unit of crown or bridge, plus an additional charge per unit as shown in the Covered Dental Services and Patient Charges section.

Pediatric Specialty Services: If, during a *PCD* visit, a *member* under age 8 is unmanageable, the *PCD* may refer the *member* to a *Participating Pediatric Specialty Care Dentist* for the current treatment plan only. Following completion of the approved pediatric treatment plan, the *member* must return to the *PCD* for further services. If necessary, *we* must first authorize subsequent referrals to the *participating specialty care dentist.* Any services performed by a *Pediatric Specialty Care Dentist* after the *member's* 8th birthday will not be covered, and the *member* will be responsible for the *Pediatric Specialty Care Dentist's* usual fees.

Second Opinion Consultation: A member may wish to consult another dentist for a second opinion regarding services recommended or performed by: (a) his or her PCD; or (b) a participating specialty care dentist through an authorized referral. To have a second opinion consultation covered by Guardian, you must call or write Member Services for prior authorization. We only cover a second opinion consultation when the recommended services are otherwise covered under the plan.

A Member Services Representative will help you identify a participating dentist to perform the second opinion consultation. You may request a second opinion with a non-participating general dentist or specialty care dentist. The Member Services Representative will arrange for any available records or radiographs and the necessary second opinion form to be sent to the consulting dentist. The second opinion consultation shall have the applicable patient charge for code D9310.

Third opinions are not covered unless requested by Guardian. If a third opinion is requested by the member, the member is responsible for the payment. Exceptions will be considered on an individual basis, and must be approved in writing by Guardian.

The *plan's* benefit for a second opinion consultation is limited to $50.00. If a *participating dentist* is the consultant *dentist,* the *member* is responsible for the applicable patient charge for code D9310. If a non-participating dentist is the consultant dentist, the member must pay the applicable patient charge for code D9310 and any portion of the dentist's fee over $50.00.

Noble and High Noble Metals: The plan provides for the use of noble metals for inlays, onlays, crowns and fixed bridges. When high noble metal (including "gold") is used, the member will be responsible for the patient charge for the inlay, onlay, crown, or fixed bridge, plus an additional charge equal to the actual laboratory cost of the high noble metal.

General Anesthesia / IV Sedation: General anesthesia or IV sedation is limited to services provided by a Participating Oral Surgery Specialty Care Dentist. Not all Participating Oral Surgery Specialty Care Dentists offer these services. The member is responsible to identify and receive services from a Participating Oral Surgery Specialty Care Dentist willing to provide general anesthesia or IV sedation. The member's patient charge is shown in the Covered Dental Services and Patient Charges section.

Office Visit Charges: Office visit patient charges that are the member's responsibility after the employer's group plan has been in effect for three full years, will be paid to the PCD by us.

GP-1-MDG-FL-COND-08 P850.0882

Options G, H, Y and Z

Orthodontic Treatment: The plan covers orthodontic services as shown in the Covered Dental Services and Patient Charges section. Coverage is limited to one course of treatment per member. We must preauthorize treatment, and treatment must be performed by a Participating Orthodontic Specialty Care 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 each additional month of treatment, based upon the Participating Orthodontic Specialty Care Dentist's contracted fee.

Except as described under Treatment in Progress - Orthodontic Treatment and Treatment in Progress - Takeover Benefit for Orthodontic Treatment, 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 Orthodontic Specialty Care Dentist may prorate his or her usual fee over the remaining months of treatment. The member is responsible for all payments to the Participating Orthodontic Specialty Care Dentist for services after the termination date. Retention services are covered at the Patient Charge shown in the Plan Schedule's section only following a course of comprehensive orthodontic treatment started and completed under this plan.

If a member transfers to another Orthodontic Specialty Care Dentist after authorized comprehensive orthodontic treatment has started under this plan, the member must pay any additional costs associated with the change in Orthodontic Specialty Care Dentist and subsequent treatment.

The benefit for the treatment plan and records includes initial records and any interim and final records. The benefit for comprehensive orthodontic treatment covers the fixed banding appliances and related visits only. Additional fixed or removable appliances will be the member's responsibility. The benefit for orthodontic retention is limited to 12 months and covers any and all necessary fixed and removable appliances and related visits. Retention 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 the standard orthodontic benefit. The member must pay any additional charges related to the orthognathic surgery and the complexity of the orthodontic treatment. The additional charge will be based on the Participating Orthodontic Specialty Dentist's usual fee.

GP-1-MDG-FL-ORTHO-08 P850.0886

Options G, H, Y and Z

Treatment In Progress

1. Treatment in Progress -

A member may choose to have a *participating dentist* complete an inlay, onlay, crown, fixed bridge, denture, or root canal, or orthodontic treatment procedure which: (1) is listed in the *Covered Dental Services and Patient Charges* Section; and (2) was started but not completed prior to the *member's* eligibility to receive benefits under this *plan.* The *member* is responsible to identify, and transfer to, a *participating dentist* willing to complete the procedure at the *patient charge* described in this section.

Restorative Treatment: Inlays, onlays, crowns and fixed bridges are started when the tooth or teeth are prepared and completed when the final restoration is permanently cemented. Dentures are started when the impressions are taken and completed when the denture is delivered to the patient. Inlays, onlays, crowns, fixed bridges, or dentures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the member's eligibility to receive benefits under this Plan, have a patient charge equal to 85% of the Participating General Dentist's usual fee. (There is no additional charge for high noble metal.)

Endodontic Treatment: Endodontic treatment is started when the pulp chamber is opened and completed when the permanent root canal filling material is placed. Endodontic procedures which are shown in the Covered Dental Services and Patient Charges section that were started but not completed prior to the member's eligibility to receive benefits under this plan may be covered if the member identifies a Participating General or Specialty Care Dentist who is willing to complete the procedure at a patient charge equal to 85% of Participating Dentist's usual fee.

Orthodontic Treatment: Comprehensive orthodontic treatment is started when the teeth are banded. Orthodontic treatment procedures which are shown in the Covered Dental Services and Patient Charges section and were started but not completed prior to the member's eligibility to receive benefits under this plan may be covered if the member identifies a Participating Orthodontic Specialty Care Dentist's who is willing to complete the treatment at a patient charge equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. In this situation, the patient charge for retention services would also be equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. When comprehensive orthodontic treatment is started prior to the member's eligibility to receive benefits under this plan, the patient charge for orthodontic retention is equal to 85% of the Participating Orthodontic Specialty Care Dentist's usual fee. Also refer to the Orthodontic Takeover - Treatment in Progress section.

2. Treatment in Progress - Takeover Benefit for Orthodontic Treatment -

The Treatment in Progress - Takeover Benefit for Orthodontic Treatment provides a member who qualifies, as explained below, a benefit to continue comprehensive orthodontic treatment that was started under another dental HMO plan with the current treating orthodontist, after this plan becomes effective.

A member may be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment only if:

- the member was covered by another dental HMO plan just prior to the effective date of this plan and had started comprehensive orthodontic treatment (D8070, D8080 or D8090) with a participating network orthodontist under the prior dental HMO plan;
- the member has such orthodontic treatment in progress at the time this plan becomes effective;
- the member continues such orthodontic treatment with the treating orthodontist;
- the member's payment responsibility for the comprehensive orthodontic treatment in progress has increased because the treating orthodontist raised fees due to the termination of the prior dental

HMO plan; and

- a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form, completed by the treating orthodontist, is submitted to us within 6 months of the effective date of this plan.

The benefit amount will be calculated based on: (i) the number of remaining months of comprehensive orthodontic treatment; and (ii) the amount by which the member's payment responsibility has increased as a result of the treating orthodontist's raised fees, up to a maximum benefit of $500 per member.

The member will be responsible to have the treating orthodontist complete a Treatment in Progress - Takeover Benefit for Orthodontic Treatment Form and submit it to Us. The member has 6 months from the effective date of this plan to have the Form submitted to us in order to be eligible for the Treatment in Progress - Takeover Benefit for Orthodontic Treatment. We will determine the member's additional payment responsibility and prorate the months of comprehensive orthodontic treatment that remain. The member will be paid quarterly until the benefit has been paid or until the member completes treatment, whichever comes first. The benefit will cease if the member's coverage under this plan is terminated.

This benefit is only available to members that were covered under the prior dental HMO plan and are in comprehensive orthodontic treatment with a participating network orthodontist when this plan becomes effective with us. It will not apply if the comprehensive orthodontic treatment was started when the member was covered under a PPO or Indemnity plan; or where no prior coverage existed; or if the member transfers to another orthodontist. This benefit applies to members of new plans only. It does not apply to members of existing plans. And it does not apply to persons who become newly eligible under the Group after the effective date of this plan.

The benefit is only available to members in comprehensive orthodontic Treatment (D8070, D8080 or D8090). It does not apply to any other orthodontic services. Additionally, We will only cover up to a total 24 months of comprehensive orthodontic treatment.

Options G, H, Y and Z

Limitations On Benefits For Specific Covered Services

NOTE: Time limitations for a service are determined from the date that service was last rendered under this *plan.*

The codes below in parentheses refer to the CDT Codes as shown in the Covered Dental Services and Patient Charges section.

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

- Routine cleaning (prophylaxis: D1110, D1120, D1999) or periodontal maintenance procedure (D4910, D4999) - a total of four (4) services in any twelve (12) month period. One (1) of the covered periodontal maintenance procedures may be performed by a Participating Periodontal Specialty Care Dentist if done within three (3) to six (6) months following completion of approved, active periodontal therapy (periodontal scaling and root planing or periodontal osseous surgery) by a Participating Periodontal Specialty Care Dentist. Active periodontal therapy includes periodontal scaling and root planing or periodontal osseous surgery.
- Fluoride treatment (D1203, D1204, D1206, D2999) four (4) in any twelve (12) month period.
- Adjunctive pre-diagnostic tests that aid in detection of mucosal abnormalities including pre-malignant and malignant lesions, not to include cytology or biopsy procedures (D0431) - limited to 1 in any 2-year period on or after the 40th birthday.
- Full mouth x-rays - 1 set in any 3-year period.
- Bitewing x-rays - 2 sets in any 12-month period.
- Panoramic x-rays - 1 set in any 3-year period.
- Sealants - limited to permanent teeth, up to the 16th birthday - 1 per tooth in any 3-year period.
- Gingival flap procedure (D4240, D4241) or osseous surgery (D4260, D4261) - a total of 1 service per quadrant or area in any 3-year period.
- Periodontal soft tissue graft procedures (D4270, D4271) or subepithelial connective tissue graft procedure (D4273) - a total of 1 service per area in any 3-year period.
- Periodontal scaling and root planning (D4341, D4342) - 1 service per quadrant or area in any 12-month period.
- Emergency dental services when more than 50 miles from the PCD's office - limited to a $50.00 reimbursement per incident.
- Emergency dental services when provided by a dentist other than the member's assigned PCD, and without referral by the PCD or authorization by MDG - limited to the benefit for palliative treatment (code D9110) only.
- Reline of a complete or partial denture - 1 per denture in 12-month period.
- Rebase of a complete or partial denture - 1 per denture in any 12-month period.
- Second Opinion Consultation - when approved by us, a second opinion consultation will be reimbursed up to $50.00 per treatment plan.

Options G, H, Y and Z

We won't pay for:

- Any condition for which benefits of any nature are recovered or found to be recoverable, whether by adjudication or settlement, under any Worker's Compensation or Occupational Disease Law, even though the *member* fails to claim his or her rights to such benefit.
- Dental services performed in a hospital, surgical center, or related hospital fees.
- Any *histopathological* examination or other laboratory charges.
- Removal of tumors, cysts, neoplasms or foreign bodies that are not of tooth origin.
- Any oral surgery requiring the setting of a fracture or dislocation.
- Placement of osseous (bone) grafts.
- Dispensing of drugs not normally supplied in a dental office for treatment of dental diseases.
- Any treatment or appliances requested, recommended or performed: (a) which in the opinion of the *participating dentist* is not necessary for maintaining or improving the Member's dental health, or (b) which is solely for cosmetic purposes.
- Precision attachments, stress breakers, magnetic retention or *overdenture* attachments.
- The use of: (a) intramuscular sedation, (b) oral sedation, or (c) inhalation sedation, including but not limited to *nitrous oxide.*
- Any procedure or treatment method: (a) which does not meet professionally recognized standards of dental practice or (b) which is considered to be experimental in nature.
- Replacement of lost, missing, or stolen appliances or prosthesis or the fabrication of a spare appliance or prosthesis.
- Any Member request for: (a) specialist services or treatment which can be routinely provided by the *PCD,* or (b) treatment by a specialist without a referral from the *PCD* and approval from *us.*
- Treatment provided by any public program, or paid for or sponsored by any government body, unless we are legally required to provide benefits.
- Any restoration, service, appliance or prosthetic device used solely to: (a) alter vertical dimension; (b) replace tooth structure lost due to attrition or abrasion; or (c) splint or stabilize teeth for *periodontal* reasons (d) realign teeth.
- Any service, appliance, device or modality intended to treat disturbances of the *temporomandibular joint (TMJ).*
- Dental services, other than covered *Emergency Dental Services,* which were performed by any *dentist* other than the Member's assigned *PCD,* unless *we* had provided written authorization.
- Cephalometric x-rays, except when performed as part of the orthodontic treatment plan and records for a covered course of comprehensive orthodontic treatment.
- Treatment which requires the services of a *Prosthodontist.*
- Treatment which requires the services of a *Pediatric Specialty Care Dentist,* after the Member's 8th birthday.
- Consultations for non-covered services.
- Any service, treatment or procedure not specifically listed in the Covered Dental Services and Patient Charges section.
- Any service or procedure: (a) associated with the placement, prosthodontic restoration or maintenance of a dental implant; and (b) any incremental charges to other covered services as a result of the presence of a dental implant.
- Inlays, onlays, crowns or fixed bridges or dentures started, but not completed, prior to the Member's

eligibility to receive benefits under this *plan,* except as described under Treatment in Progress-Restorative Treatment. (Inlays, onlays crowns or fixed bridges are (a) started when the tooth or teeth are prepared, and (b) completed when the final restoration is permanently cemented. Dentures are (a) started when the impressions are taken, and (b) completed when the denture is delivered to the Member.)

- Root canal treatment started, but not completed, prior to the Member's eligibility to receive benefits under this plan, except as described under Treatment in Progress-Endodontic Treatment. (Root canal treatment is: (a) started when the pulp chamber is opened, and (b) completed when the permanent root canal filling material is placed.)
- Orthodontic treatment started prior to the Member's eligibility to receive benefits under this plan, except as described under Treatment in Progress-Orthodontic Treatment and Treatment in Progress - Takeover Benefit for Orthodontic Treatment. (Orthodontic treatment is started when the teeth are banded.)
- Inlays, onlays, crowns, fixed bridges or dentures started by a non-participating dentist. (Inlays, onlays, crowns and fixed bridges are considered to be started when the tooth or teeth are prepared. Dentures are started when the impressions are taken.) This exclusion will not apply to services that are started and which were covered, under the plan as Emergency Dental Services.
- Root canal treatment started by a non-participating dentist. (Root canal treatment is considered to be started when the pulp chamber is opened.) This exclusion will not apply to services that were started and which were covered, under the plan as Emergency Dental Services.
- Orthodontic treatment started by a Non-Participating Dentist while the Member is covered under this Plan. (Orthodontic treatment is considered to be started when the teeth are banded.)
- Extractions performed solely to facilitate orthodontic treatment.
- Extractions of impacted teeth with no radiographic evidence of pathology. The removal of impacted teeth is not covered if performed for prophylactic reasons.
- Orthognathic surgery (moving of teeth by surgical means) and associated incremental charges.
- Clinical crown lengthening (D4249) performed in the presence of periodontal disease on the same tooth.
- Procedures performed to facilitate non-covered services, including but not limited to: (a) root canal therapy to facilitate overdentures, hemisection or root amputation, and (b) osseous surgery to facilitate either guided tissue regeneration or an osseous graft.
- Procedures, appliances or devices: (a) guide minor tooth movement or (b) to correct or control harmful habits.
- 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.
- Re-treatment of orthodontic cases, or changes in orthodontic treatment necessitated by any kind of accident.
- Replacement or repair of orthodontic appliances damaged due to the neglect of the Member.

Options G, H, Y and Z

Converting This Group Dental Insurance

Important Notice: This section applies only to dental expense coverages. In this section these coverages are referred to as "group dental benefits."

If An Employee's Group Dental Benefits End: If an Employee's 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 Policy for at least 3 consecutive months immediately prior to the date his or her group dental benefits end. The converted policy will cover the Employee and those of his eligible Dependents whose group dental benefits end.

If An Employee Dies While Insured: If an Employee 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 Employee's Dependent 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.

If An Employee's Marriage Ends: If an Employee's marriage ends by legal divorce or annulment, and if the former spouse is dependent upon the Employee for financial support, his or her former spouse can convert. The converted policy will cover the former spouse and those of the Employee's Dependent children whose group dental benefits end.

When a Dependent Loses Eligibility: When an insured Dependent stops being an eligible Dependent, as defined in this Policy, he or she may convert. The converted policy will only cover the Dependent whose group dental benefits end.

How and When to Convert: To convert, the applicant must apply to us in writing and pay the required premium. He has 31 days after his or her 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.

The Converted Policy: 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 the 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 Policy.

GP-1-MDG-FL-CONV P850.0065

Options G, H, Y and Z

Definitions

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.

GP-1-MDGD1 P850.0066

Options G, H, Y and Z

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

GP-1-MDGD2 P850.0067

Options G, H, Y and Z

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.

GP-1-MDGD3 P850.0068

Options G, H, Y and Z

Dependent means a person listed on the Employee's enrollment form who is any of the following:

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

   The term "dependent child" as used in this plan includes any: (a) stepchild; (b) newborn child; (c) legally adopted child; or (d) child for whom the Employee is the court-appointed legal guardian. The term also includes any child for whom a court-ordered decree requires the Employee to provide dependent coverage, and any proposed adoptive child during any waiting period prior to the formal adoption.
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 the *employee* for support and maintenance. The *employee* 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.

GP-1-MDG-D4-10-L P850.1024

Options G, H, Y and Z

Emergency Dental Services 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 Emergency Dental Services.

GP-1-MDGD5 P850.0070

Options G, H, Y and Z

Employee means a person who works for the Policyholder at the Policyholder's 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 determined by the Policyholder, and who is enrolled hereunder and for whom monthly payments are made by an employer.

GP-1-MDGD6 P850.0071

Options G, H, Y and Z

Employer, Planholder or Policyholder means the employer or other entity with whom or to whom this Policy is issued, and who agrees to collect and pay the applicable premium on behalf of all its Members.

GP-1-MDGD7 P850.0073

Options G, H, Y and Z

Member means an Employee and any eligible Dependents, as defined under the eligibility requirements of this Policy and as determined by the Policyholder, who are actually enrolled in and eligible to receive benefits under this Policy.

GP-1-MDGD8 P850.0074

Options G, H, Y and Z

Non-Participating Dentist means any Dentist that is not under contract with The Guardian to provide services to Members.

GP-1-MDGD9 P850.0076

Options G, H, Y and Z

Participating Dentist means a licensed Dentist under contract with The Guardian and shall include any hygienists and technicians recognized by the dental profession who assist and act under the supervision of a Participating Dentist.

GP-1-MDGD10 P850.0077

Options G, H, Y and Z

Participating General Dentist means a licensed Dentist under contract with The Guardian who is listed in The Guardian's directory of Participating Dentists as a general practice Dentist, and who may be selected as a Primary Care Dentist by a Member to provide or arrange for a Member's dental services.

GP-1-MDGD11 P850.0078

Options G, H, Y and Z

Participating Specialist Dentist means a licensed Dentist under contract with The Guardian as an Endodontist, Pediatric Specialist Dentist, Periodontist, Oral Surgeon or Orthodontist.

GP-1-MDGD12 P850.0079

Options G, H, Y and Z

Patient Charge means the amount, if any, specified in the Covered Dental Services and Patient Charges section of this Policy, which represents the patient's portion of the cost of covered dental procedures.

GP-1-MDGD13 P850.0080

Options G, H, Y and Z

Plan or Policy means The Guardian Group Policy for Dental Services described herein.

GP-1-MDGD14 P850.0081

Options G, H, Y and Z

Primary Care Dentist means a Participating General Dentist, selected by a Member, who is responsible for providing and arranging for a Member's dental services.

GP-1-MDGD15 P850.0082

Options G, H, Y and Z

Service Area means the geographic area in which The Guardian has arranged to provide for dental services for Members.

GP-1-MDGD16 P850.0083

Options G, H, Y and Z

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

GP-1-MDGD17 P850.0084

Options G, H, Y and Z

You, Your or Policyholder means the employer who purchased this Policy.

GP-1-MDGD18 P850.0085

Options G, H, Y and Z

COORDINATION OF BENEFITS

Applicability

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, trusteed 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 governmental 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.

How This Provision Works: The Order of Benefits

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;

(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 a 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 covered person was eligible under the second within 24 hours after the first plan ended.

The Member's length of time covered under a 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.

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.

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 Members' out-of-pocket expense.

Our Right To Certain Information

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.

Options G, H, Y and Z

STATEMENT OF ERISA RIGHTS

As a participant, an employee is 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 the employee 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.

GP-1-MDGER P850.0695

* * * * *

The foregoing amendment shall form a part of said Group Policy, provided both the Policyholder and the Insurance Company have hereto applied their respective signatures, and is subject to the agreements and covenants therein contained.

Dated at New York, NY This 12th Day of May , 2017

PEDIATRIC HEALTH CARE ALLIANCE ADMINISTRATION LLC
Full or Corporate Name of Policyholder

_____ BY: _____
Witness Signature and Title

The Guardian Life Insurance Company of America

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

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

GUR-1 P600.9002

END OF POLICY DOCUMENT