



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

**YOUR GROUP INSURANCE  
PLAN BENEFITS**

**CAMDENTON RIII SCHOOL DISTRICT  
CLASS 0002  
OPTIONAL LIFE, DENTAL BUY-UP, VISION**

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

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**CERTIFICATE OF COVERAGE**

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**The Guardian**  
7 Hanover Square  
New York, New York 10004

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

Group Policy No.	Certificate No.	Effective Date
Issued To		

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

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

CGP-3-R-STK-90-3

B110.0023



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**IMPORTANT NOTICE**

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

1-800-873-4542

CGP-3-R-ADD-MO-92

B120.0055



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## GENERAL PROVISIONS

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As used in this booklet:

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

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

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

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

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

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

CGP-3-R-GENPRO-90

B160.0002

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## Limitation of Authority

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

CGP-3-R-LOA-90-MO

B160.0026

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## Incontestability

This *Plan* is incontestable after two years from the earlier of its effective date or its date of issue, except for non-payment of premiums.

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

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

CGP-3-R-INCY-90-MO

B160.0027

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## Examination and Autopsy

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

CGP-3-R-EA-90

B160.0006

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## Accident and Health Claims Provisions

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

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

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

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

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

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

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

## Accident and Health Claims Provisions (Cont.)

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When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But, we will pay health care benefits, with or without a written authorization from you, if the recognized provider of health care is a public hospital or clinic that has submitted a proper claim, and if such health care benefits have not previously been paid to you. But we can't tell you that a particular provider provide such care. And you may not assign your right to take legal action under this *plan* to such provider.

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

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

CGP-3-R-MO-93

B160.0041

## **An Important Notice About Continuation Rights**

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

CGP-3-R-NCC-87

B240.0064

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## YOUR CONTINUATION RIGHTS

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### Federal Continuation Rights

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

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

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

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

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

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

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

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

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

## Federal Continuation Rights (Cont.)

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

CGP-3-R-COBRA-96-1

B235.0164

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

CGP-3-R-COBRA-96-2

B235.0075

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

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

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

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

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

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



## Federal Continuation Rights (Cont.)

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

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

CGP-3-R-COBRA-96-3

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### **Your Employer's Responsibilities**

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

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

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

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

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

### **Your Employer's Liability**

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

## Federal Continuation Rights (Cont.)

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

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

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

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

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

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

- (1) with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
- (2) with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;
- (3) with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
- (4) the date the employer ceases to provide any group health plan to any employee;

## Federal Continuation Rights (Cont.)

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- (5) the end of the period for which the last premium payment is made;
- (6) the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or
- (7) the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4

B235.0198

## Uniformed Services Continuation Rights

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

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

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

CGP-3-R-COBRA-96-4

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## YOUR CONTINUATION RIGHTS

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### Important Notice

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This section applies to an employee's group term life benefits. These benefits are referred to as "group life benefits."

This section does not apply to accidental death and dismemberment benefits.

### A Totally Disabled Employee's Right to Continue Group Life Benefits

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**If an Employee is Totally Disabled** If an employee's group life benefits end while the employee is totally disabled, he may continue such benefits for a limited period of time subject to the payment of premiums.

In this section, an employee is totally disabled if: (a) he is not able to engage in his regular occupation, or any other occupation for which he is qualified by reason of his education, training or experience; and (b) he becomes so disabled while insured by this group plan.

This continuation will end on the later of: (a) six months, starting on the date the total disability began; or (b) for employees who meet our standard for total disability under the extended life benefits section of this plan, the end of the waiting period which applies to the permanent disability provision under that section.

The monthly premium the employee must pay to continue his group life benefits will be the amount which he would have been required to pay had he stayed insured by this group plan on a regular basis. He must make this payment to his employer at the times and in the manner specified by his employer. If the employee fails to pay this amount on time, he waives his right to continue his group life benefits.

If the employer fails, after timely receipt of any required employee payment, to pay us on behalf of such employee, thereby causing the employee's group life benefits to end, then the employer will become liable for the employee's group life benefits to the same extent as, and in place of, us.

**When the Continued Group Life Benefits End** An employee's continued life benefits end on the first of the following:

- (a) the end of the applicable continuation period;
- (b) the end of the period for which the last total monthly premium payment was made to us;
- (c) the date the group plan ends or is amended to end benefits for the class of employees to which the employee belonged;
- (d) the date the employee is no longer totally disabled; or

## A Totally Disabled Employee's Right to Continue Group Life Benefits (Cont.)

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- (e) the date the employee is approved by us in writing for coverage under any permanent disability provision of the extended life benefits section of this plan.

**Conversion Rights and Extended Life Benefits** Any applicable conversion rights will still be in effect when the continuation period ends. Continuing his group life benefits under this section does not stop an employee from claiming his rights under the extended life benefits section of this plan.

CGP-3-R-CC-MO-83

B240.9007

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### Dependent Continuation Rights

**Important Notice** This section applies to the hospital, surgical, major medical, dental, vision care and prescription drug expense coverages only. In this section, these coverages are referred to as "group health benefits."

This section does not apply to coverages which provide benefits for loss of life or loss of income due to disability. These coverages, if provided, cannot be continued under this section.

Any continuation of group health benefits under this section shall be subject to all of the terms and conditions of this plan.

**If an Employee's Marriage Ends or If an Employee Dies While Insured** If an employee's marriage ends by legal separation or divorce, or if an employee dies while insured, his or her then insured spouse may continue this plan's group health benefits after federal continuation ends, subject to all the terms below and to the timely payment of premiums. Such group health benefits will cover such spouse and those of the employee's dependent children whose group health benefits would otherwise end.

How and When to Continue the Group Health Benefits: To continue the group health benefits, the employee's spouse must:

- (a) be insured for group health benefits under this plan at the time the marriage ends or the employee dies;
- (b) be age 55 or older when federal continuation ends;
- (c) in the case of a divorced or separated spouse, give notice to the employer within 60 days of legal separation or divorce, or prior to the expiration of a 36 month federal continuation;
- (d) in the case of a surviving spouse, give notice to the employer within 30 days of the employee's death, or prior to the expiration of a 36 month federal continuation; and
- (e) elect to continue the group health benefits, provide current mailing address and pay the first monthly premium. This must be done within 60 days after receiving a written notice of continuation rights from the employer. The notice will be sent to the spouse's last known address within 14 days of receipt of notice of the employee's divorce, legal separation or death.

## Dependent Continuation Rights (Cont.)

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The notice of continuation rights will: (i) contain a form for electing to continue the group health benefits; and (ii) explain all the details for continuing the group health benefits, including:

- (a) the duration of the continuation coverage;
- (b) the monthly premium that must be paid to continue the group health benefits; and
- (c) the times and manner in which premium payments must be made.

If the employee's spouse fails to give the employer notice or fails to pay any premium on time, he or she waives his or her right to continue the group health benefits under this plan.

If the employer fails to provide the spouse with written notice of his or her continuation rights, after being notified by the spouse as explained above, the spouse's coverage will continue in effect. His or her obligation to make premium payments will be postponed, but not reduced or eliminated, for the period of time beginning on the date his or her coverage would otherwise end until 31 days after the date the employer provides the required notice.

**When Continuation Ends** This continuation ends for each covered person on the earliest of the following:

- (a) the end of the period for which the last premium payment was made;
- (b) the date the group plan ends and is not replaced;
- (c) the date the covered person becomes insured under another group plan;
- (d) the date the spouse remarries;
- (e) the date the spouse reaches age 65; or
- (f) with respect to each insured dependent, the date such dependent ceases to be an eligible dependent as defined in the group plan.

**The Right to Convert** At the end of the continuation period under this section, conversion rights which the covered person may be entitled to shall be available to him or her according to the terms of the plan.

CGP-3-R-CC-MO-96

B240.0210

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## CERTIFICATE AMENDMENT

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(To be attached to certificates issued to employees)

**Group Policy No.:** G-00477134-

**Issued to:** CAMDENTON RIII SCHOOL DISTRICT

**Amendment Effective:** Effective September 4, 2009, or the earlier of the effective date of any major medical, prescription drug, dental or vision coverage under this plan; or your first renewal on or following September 4, 2009

This rider amends this plan's group health benefits provisions so that the following is added to this plan:

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## YOUR CONTINUATION RIGHTS

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### **State MoCOBRA - For Employer Groups of 2-19**

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**Important Notice** This section applies only to any major medical, dental, vision and/or prescription drug coverages which are part of this plan. In this section, these coverages are referred to as "group health benefits."

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

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

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

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

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

## State MoCOBRA - For Employer Groups of 2-19 (Cont.)

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

To elect the extra 11 months of continuation, a qualified continuee must give ADP COBRA Services (ADP) 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 ADP 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 cost of coverage also may be required from all qualified continuees who are members of the disabled qualified continuee's family by your employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

**Special Continuance for Retired Employees and their Dependents** If your group health benefits end due to a bankruptcy proceeding under Title 11 of the United States Code involving the employer, you may elect to continue such benefits, provided that

- (a) you are or become a retired employee on or before the date group health benefits end; and
- (b) you and your dependents were covered for group health benefits under this plan on the day before the bankruptcy proceeding under Title 11 of the United States Code.

The continuation can last for your lifetime. After your death, the continuation period for a dependent can last for up to 36 months.

For purposes of this special continuance, a substantial elimination of coverage for you and your dependents within one year before or after the start of such proceeding will be considered loss of coverage.

If you die before the bankruptcy proceeding under Title 11 of the United States Code, your surviving spouse and dependent children may elect to continue group health benefits on their own behalf, provided they were covered on the day before such proceedings. The continuation can last for your surviving spouse's lifetime.

This special continuance starts on the later of: (a) the date of the proceeding under Title 11; or (b) the day after the date group health benefits would have ended. It ends as described in "When Continuation Ends", except that a person's entitlement to Medicare will not end such continuance.



## State MoCOBRA - For Employer Groups of 2-19 (Cont.)

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

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

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

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

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

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

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

## State MoCOBRA - For Employer Groups of 2-19 (Cont.)

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Notice of a disability determination must be given to your employer 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.

CGP-A-1

B250.0014

### **Your Employer's Responsibilities**

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

Such written notice must be given to the qualified continuee within 14 days of: (a) the date a qualified continuee's group health benefits would otherwise end due to your death or your termination of employment or reduction of work hours; (b) the date a qualified continuee notifies your employer, in writing, of your legal divorce or legal separation from your spouse, or the loss of dependent eligibility of an insured dependent child; or (c) the date your employer declares bankruptcy under Title 11 of the United States Code.

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

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

### **Your Employer's Liability**

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

### **Election of Continuation**

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

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

## **State MoCOBRA - For Employer Groups of 2-19 (Cont.)**

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

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

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

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

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

## State MoCOBRA - For Employer Groups of 2-19 (Cont.)

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

**The Guardian** Life Insurance Company of America

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

CGP-A-1

B250.0015

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## ELIGIBILITY FOR LIFE COVERAGES

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B264.0002

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### Employee Coverage

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

**Other Conditions** You must:

- (a) be legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.
- (b) be regularly working at least the number of hours in the normal work week set by your *employer* (but not less than 20 hours per week), at:
  - (i) your *employer's* place of business;
  - (ii) some place where your *employer's* business requires you to travel; or
  - (iii) any other place you and your *employer* have agreed upon for performance of occupational duties.

If you must pay all or part of the cost of employee coverage, we won't insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we also ask for *proof* that you're insurable. And you won't be covered until we approve that *proof* in writing.

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

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

CGP-3-EC-90-1.0

B264.2298

**When Your Coverage Starts** Employee benefits that don't require *proof* that you are insurable are scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet.

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

## Employee Coverage (Cont.)

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

Sometimes, the effective date shown on the sticker or in the endorsement is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; or during an approved leave of absence, not due to sickness or injury, of 90 days or less; and if you were performing the major duties of your regular occupation and working your regular number of hours on your last regularly scheduled work day, your coverage will start on the scheduled effective date. However, any coverage or part of coverage for which you must elect and pay all or part of the cost, will not start if you are on an approved leave and such coverage or part of coverage was not previously in force for you under a prior plan which this *plan* replaced.

CGP-3-EC-90-2.0

B264.0690

### **Delayed Effective Date For Employee Optional Life Coverage**

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

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

CGP-3-DEF-97

B270.0384

### **When Your Coverage Ends**

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

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

It ends on the date you are no longer working in the United States, or working outside of the United States for a United States based employer in a country or region approved by us.

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

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time. And you may have the right to replace certain group benefits with converted policies.

CGP-3-EC-90-3.0

B264.2362

### Your Right To Continue Group Life Insurance During A Family Leave Of Absence

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

**Continuation of Coverage** Life insurance may be continued at your employer's option. You must contact your employer to find out if you may continue this insurance.

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

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

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

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

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

CGP-3-EC-90-3.0

B264.2452

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## Dependent Life Coverage

CGP-3-DEP-90-1.0

B264.0056

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## Dependent Coverage

**Eligible Dependents For Optional Dependent Life Benefits** Your *eligible dependents* are: your legal spouse who is under age 70; and your unmarried dependent children who are 14 or more days old, until they reach age 26 and your unmarried dependent children, from age 26 until they reach age 26, who are enrolled as full-time students at accredited schools.

CGP-3-DEP-90-3.0

B264.0579

**Adopted Children And Step-Children** Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.



## Dependent Coverage (Cont.)

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**Dependents Not Eligible** We exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0

B264.0587

**Proof Of Insurability** We require *proof* that a dependent is insurable, if you: (a) enroll a dependent and agree to make the required payments after the end of the *enrollment period*; (b) in the case of a newly acquired dependent, other than the first newborn child, have other eligible dependents who you have not elected to enroll; or (c) in the case of a *newly acquired dependent*, have other *eligible dependents* whose coverage previously ended because you failed to make the required contributions, or otherwise chose to end such coverage.

A dependent is not insured by any part of this *plan* that requires such *proof* until you give us this *proof*, and we approve it in writing.

If the dependent coverage ends for any reason, including failure to make the required payments, your dependents won't be covered by this *plan* again until you give us new *proof* that they're insurable and we approve that *proof* in writing.

CGP-3-DEP-90-5.0

B200.0288

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

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

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

If you do this after the *enrollment period* ends, your dependent coverage is subject to *proof of insurability* and won't start until we approve that *proof* in writing.

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

A *newly acquired dependent* will be covered for those dependent benefits not subject to *proof of insurability* from the date the newly acquired dependent is first eligible, if you notify us and agree to make any additional payments within 31 days after the date the dependent becomes eligible. If you do this more than 31 days after the date the dependent becomes eligible, a *newly acquired dependent* will be covered from the date you notify us and agree to make any additional payments.

If *proof of insurability* is required for dependent benefits as explained above, those benefits are scheduled to start, subject to the "Exception" stated below, on the effective date shown in the "Endorsement" section of your application, provided that you send us the *proof* we require and we approve that *proof* in writing. A copy of the approved application is furnished to you.

CGP-3-DEP-90-6.0

B264.1129

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

CGP-3-DEP-90-7.0

B200.0692

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

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

An individual dependent's coverage ends when he stops being an *eligible dependent*. This happens to a child at 12:01 a.m. on the date the child attains this *plan's* age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse when a marriage ends in legal divorce or annulment, and with respect to optional life coverage, it happens at 12:01 a.m. on the date the spouse reaches age 70.

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

CGP-3-DEP-90-9.0

B200.0792

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## GROUP TERM LIFE INSURANCE SCHEDULE

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### Employee Optional Contributory Term Life Insurance

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CGP-3-R-SCH-90

B265.0055

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

CGP-3-R-SCH-90

B265.0799

**Your Optional Term Life Insurance Amount** *Plan A*

You may elect amounts of optional term life insurance in increments of \$10,000.00, but your amount may not be less than \$10,000.00 and may not exceed \$500,000.00.

CGP-3-R-SCH-90

B265.0063

**Reduction of Optional Life Insurance Amount Based on Age**

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

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

If an employee is less than age 70 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 70, by 60% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 70 but before he or she reaches age 75.

If an employee is less than age 75 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 75, by 75% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 75 but before he or she reaches age 80.

If an employee is less than age 80 when his or her insurance under this plan starts, the employee's insurance amount is reduced, when he or she reaches age 80, by 85% of the amount which otherwise applies to his or her classification and/or option. But in no case will such reduced amount be less than \$1,000.00.

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## Employee Optional Contributory Term Life Insurance (Cont.)

The preceding reduction also applies to an employee's initial insurance amount if his or her insurance starts after he or she reaches age 80.

CGP-3-R-SCH-90

B265.0522

### **Proof of Insurability Requirements**

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

We require *proof* as follows:

CGP-3-R-SCH-90

B265.0431

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

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

We require *proof* for amounts of optional term life insurance in excess of \$200,000.00.

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

CGP-3-R-SCH-90

B265.0697

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

CGP-3-R-SCH-90

B265.0702

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## Dependent Optional Term Life Insurance

### **Dependent Optional Life Election**

You may choose the plan of dependent spouse optional term life insurance, and the plan of dependent child optional term life insurance shown below. You must notify the employer of your elections and pay the required premium.

CGP-3-R-SCH-90

B265.0800

### **Your Optional Dependent Spouse Term Life Insurance Amount**

#### **Plan A**

An amount equal to 50% of your optional term life insurance amount, to a maximum of \$250,000.00.

CGP-3-R-SCH-90

B265.0511

## Dependent Optional Term Life Insurance (Cont.)

Your Optional Dependent Child Insurance Amount	<i>Plan A</i> Child's Age At Death	Benefit Amount (expressed as a % of your optional term life insurance amount)
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At least 14 days but less than 6 months . . . . .	10% to a maximum of \$10,000.00
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At least 6 months but less than 26 years . . . . .	10% to a maximum of \$10,000.00
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At least 26 years but less than 26 years if a full-time student . . . . .	10% to a maximum of \$10,000.00
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CGP-3-R-SCH-90	B265.0653
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In no event may the insurance amount of a dependent spouse exceed 50% of the insurance amount of an employee.

In no event may the insurance amount of a dependent child exceed 10% of the insurance amount of an employee.

CGP-3-R-SCH-90	B265.0844
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**Proof of Insurability Requirements** Proof of insurability requirements apply to your dependent optional term life insurance. Such requirements may apply to the full benefits amount or just part of them. When proof of insurability requirements apply, it means you must submit to us proof that a dependent is insurable, and we must approve the proof in writing before the insurance, or the specified part becomes effective.

We require proof as follows:

CGP-3-R-SCH-90	B265.0536
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We require proof before we will insure any spouse who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90	B265.0540
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We require proof for any increase in the amount of dependent optional term life insurance with respect to a dependent spouse.

CGP-3-R-SCH-90	B265.0863
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We require proof for any amount of dependent optional term life insurance in excess of \$ 50,000.00 with respect to your dependent spouse.

CGP-3-R-SCH-90	B265.0542
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We require proof for any amount of dependent optional term life insurance in excess of \$5,000.00 with respect to your dependent spouse, if your dependent spouse's scheduled dependent optional term life effective date is after he or she reaches age 65.

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## **Dependent Optional Term Life Insurance (Cont.)**

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We require proof before we will insure any child who is enrolled for dependent optional term life insurance after the time allowed for enrolling as specified in this plan.

CGP-3-R-SCH-90

B265.0549

We require proof for any increase in the amount of dependent optional term life insurance with respect to a dependent child.

CGP-3-R-SCH-90

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**Your Optional Group Term Life Insurance**

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- Life Benefit** Subject to the limitations and exclusions below, if you die while insured for this benefit, we'll pay your beneficiary the amount shown in the schedule for the plan of benefits you have elected. Your life benefit may be subject to reductions based on your age. These reductions are also shown in the schedule. Your benefit amount, a portion thereof, or increases in such amount may not become effective until you submit *proof of insurability* to us, and we approve it in writing. These requirements are also shown in the schedule.
- Proof of Death** Subject to all of the terms of this *plan*, we'll pay this insurance as soon as we receive written proof of death which is acceptable to us. This should be sent to us as soon as possible.
- Suicide Exclusion** We pay no benefits if your death is due to suicide, if such death occurs within two years from your employee optional group term life insurance effective date under this *plan* and we can show that you intended suicide when you applied for this plan. Also, we pay no increased benefit amount if your death is due to suicide, if such death occurs within two years from the effective date of the increase and we can show that you intended suicide when you applied for this *plan*.
- Seatbelt and Airbag Benefits** If you die as a direct result of an automobile accident while properly wearing a seatbelt, we will increase your benefit amount by \$10,000.00. And if you die as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase your benefit amount by an additional \$5,000.00, for a total increase of \$15,000.00.
- Your Beneficiary** You decide who gets this insurance if you die. You should have named your beneficiary on your enrollment form. You can change your beneficiary at any time by giving your employer written notice, unless you've assigned this insurance. But the change won't take effect until your employer gives you written confirmation of the change.
- If you named more than one person, but didn't tell us what their shares should be, they'll share equally. If someone you named dies before you do, his or her share will be divided equally by the beneficiaries still alive, unless you've told us otherwise.
- If there is no beneficiary when you die, we'll pay the insurance to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; or (e) your brothers and sisters.
- Assigning Your Life Insurance** If you assign this insurance, you permanently transfer all your rights under this insurance to the assignee. Only one of the following can be an assignee: (a) your spouse; (b) one of your parents or grandparents; (c) one of your children or grandchildren; (d) one of your brothers or sisters; or (e) the trustee(s) of a trust set up for the benefit of one or more of these relatives.

## Your Optional Group Term Life Insurance (Cont.)

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

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

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

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

**Payment of Funeral or Last Illness Expense** We have the option of paying up to \$2,000.00 of this insurance to any person who incurs expenses for your funeral or last illness.

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

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## Portability Privilege

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

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

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

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

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

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



## Portability Privilege (Cont.)

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

You may port: (a) the full amount(s) of your dependent Optional term life insurance as of the day your coverage under this *plan* ends; or (b) 50% of such amount(s), if: (i) your dependent spouse amount under this *plan* is at least \$20,000.00; and (ii) your dependent child amount under this *plan* is at least \$4,000.00. However, if you port the full amount of your insurance, any dependent amount(s) ported must be a full amount. And, if you elect to port 50% of your insurance, any dependent amount(s) ported must be 50% of such amount(s).

You may port: (a) your insurance only; (b) your insurance and insurance of your covered spouse; (c) your insurance and the insurance of all of your covered dependents; or (d) if you are a single parent, your insurance and the insurance of all of your covered dependent children. No other combinations will be allowed.

To be eligible to port, a dependent must be insured as of the day your coverage under this *plan* ends.

**If You Die While Insured** If you die while insured for dependent Optional term life insurance, your spouse may port the insurance of your dependents as described above. But, your spouse and dependents must be insured on the date of death. No dependents will be allowed to port if: (a) there is no surviving spouse; or (b) your surviving spouse has reached his or her 70th birthday on the day you die.

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

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

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

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

CGP-3-R-LP-00

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## **Information About Conversion and Portability**

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

CGP-3-R-LPN-95

B270.0326

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

## **Converting This Group Term Life Insurance**

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

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

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

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

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

If you: (a) are not disabled, as defined in the section labeled "Extended Life Benefit With Waiver of Premium", when this coverage ends; and (b) you have been insured by a Guardian group life plan for at least five years, you can convert to a permanent life insurance policy. But, the amount you can convert is limited to the lesser of: (a) \$10,000.00; or (b) the amount of your insurance under this plan, less any group life benefits you become eligible for in the 31 days after this insurance ends.

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

## Converting This Group Term Life Insurance (Cont.)

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

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

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

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

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

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

CGP-3-R-LCONV-99

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## Your Accelerated Life Benefit

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

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

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

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

## Your Accelerated Life Benefit (Cont.)

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

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

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

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

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

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

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

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

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

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

## Your Accelerated Life Benefit (Cont.)

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

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

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

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

**If You Have  
Assigned Your  
Group Term Life  
Insurance**

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

CGP-3-R-EALB-95

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**If You Are  
Incompetent**

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

**Your Remaining  
Group Term Life  
Insurance**

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

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

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

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

## Your Accelerated Life Benefit (Cont.)

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

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

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

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## Extended Life Benefit With Waiver Of Premium

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

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

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

- (a) not able to perform, on a full-time basis, the material and substantial duties of any occupation, for which you are qualified for by training, education, or experience; and
- (b) you are receiving regular doctor's care appropriate to the cause of disability.

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

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

- (a) become totally disabled before you reach age 60 and while insured by the group plan; and
- (b) remain totally disabled for 180 consecutive days.

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

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

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

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

**Until You've Been Approved For This Extended Life Benefit** Your life insurance under the group plan may end after you've become totally disabled, but before we've approved you for this extension. During this time period, you may either:

- (a) continue group premium payments, including any portion which would have been paid by the employer until you are approved or declined for this extended life benefit; or
- (b) convert to an individual permanent or term policy. Please read the section labeled "Converting This Group Term Life Insurance" for details on how to convert.

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

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

**When This Extension Begins** Once approved by us, your extended benefit will be effective on the later of:

- (a) 180 consecutive days from the date active full-time service ends due to total disability; or
- (b) the date we approve you for this benefit.

Once you are approved for this extension, we'll refund all optional term life insurance premiums paid by you from the date of disability.

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**When This Extension Ends** Your extension will end on the earliest of:

- (a) the date you are no longer disabled;
- (b) the date we ask you to be examined by our doctor, and you refuse;
- (c) the date you do not give us the proof of disability we require;
- (d) the date you are no longer receiving regular doctor's care appropriate to the cause of disability; or
- (e) the day before the date you reach age 65.

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

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

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

**Proof Of Death** We'll pay as soon as we receive

- (a) written proof of your death, that is acceptable to us; and
- (b) medical proof that you were continuously disabled until your death. This must be sent within one year of your death.

CGP-3-R-LW-TD-99-2

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## Your Dependent Spouse and Child Optional Term Life Insurance

**The Benefit** Subject to the limitations and exclusions shown below, if one of your dependents dies while insured for this benefit, we pay the amount shown in the schedule for the plan you have elected. We pay this in a lump sum when we receive written proof of death which is acceptable to us. Send the proof to us as soon as possible.

We pay you, if you're living. If you're not, and the dependent was your child, we pay your spouse. If your spouse is not living, we pay the child's living brothers and sisters in equal shares. If there are none, we pay the child's estate. If the dependent was your spouse, we pay your spouse's estate.

**Suicide Exclusion** We pay no benefits if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the dependent's optional term life insurance under this *plan* and we can show that the dependent intended suicide when he or she applied for this *plan*. Also, we pay no increased benefit amount if the dependent's death is due to suicide, if such death occurs within two years from the effective date of the increase and we can show that the dependent intended suicide when he or she applied for this *plan*.

**Seatbelt and Airbag Benefits** If a dependent dies as a direct result of an automobile accident while properly wearing a seatbelt, we will increase the benefit amount by \$5,000.00. And if a dependent dies as a direct result of an automobile accident while both properly wearing a seatbelt, and sitting in a seat equipped with an airbag, we'll increase the benefit amount by an additional \$2,500.00, for a total increase of \$7,500.00.

**Payment to a Minor or Incompetent** If the beneficiary is a minor or not competent, we have the right to pay in monthly installments. We would pay the person who cares for and supports the beneficiary. We completely discharge our liability for any amounts paid this way.

CGP-3-R-DOPT-96-MO

B293.0330



## **Converting This Dependent Term Life Insurance**

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**If Your Group Life Insurance Ends or You Stop Being Eligible** Dependent term life insurance ends for all of your dependents when your group life insurance ends. Your insurance ends when: (a) your active full-time employment ends; (b) you stop being a member of a class of employees eligible for employee group life insurance; (c) your group life insurance is extended under the Extended Life Benefit provision; or (d) you die.

Dependent term life insurance also ends when you stop being a member of a class of employees eligible for dependent term life insurance.

If one of the above happens, each dependent who was insured may convert all or part of his or her insurance.

**If This Plan Ends or Life Insurance is Dropped** Dependent term life insurance also ends for all of your dependents when this plan ends. And it ends if either employee or dependent term life insurance is dropped from this plan for all employees or for your class.

If one of the above happens, and your dependents have been insured by a Guardian group plan for at least five years, they can convert. But we limit the amount each dependent can convert to the lesser of: (a) \$10,000.00; and (b) the amount of his or her insurance under this plan less any group life benefits for which he or she becomes eligible in the 31 days after this insurance ends.

**If a Dependent Stops Being Eligible** A dependent's term life insurance ends when he or she stops being an eligible dependent as defined by this plan. If a dependent stops being eligible, that dependent can convert all or part of his or her insurance.

**The Converted Policy** The dependent can convert to one of the individual life insurance policies we normally issue. That policy can't include disability benefits. And it can't be a term policy.

The premium for the converted policy will be based on: (a) the dependent's risk and rate class under this plan; and (b) the dependent's age when the converted policy takes effect. The converted policy takes effect at the end of the period allowed for conversion.

Write to us for details.

**How and When to Convert** To get a converted policy, the dependent must apply to us in writing and pay the required premium. He or she has 31 days after his or her group insurance ends to do this. We won't ask for proof that he or she is insurable.

If the dependent is a minor or not competent, the person who cares for and supports the dependent may apply for him or her.

**Death During the Conversion Period** If a dependent dies in the 31 days allowed for conversion, we pay the amount he or she could have converted, as stated above. We do this whether or not he or she applied for conversion.

## Converting This Dependent Term Life Insurance (Cont.)

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

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

CGP-3-R-DEPL-03-N

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## ELIGIBILITY FOR DENTAL COVERAGE

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### Employee Coverage

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

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

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

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

CGP-3-EC-90-1.0

B489.0122

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

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

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

CGP-3-EC-90-2.0

B489.0070

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

Your coverage ends on the date you die.

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

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

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

CGP-3-EC-90-3.0

B489.0075

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

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

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

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

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

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

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

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

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- **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.

CGP-3-EC-90-3.0

B449.0727

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## Dependent Coverage

B200.0271

### Eligible Dependents For Dependent Dental Benefits

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

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

CGP-3-DEP-90-2.0

B489.0309

## Dependent Coverage (Cont.)

**Adopted Children And Step-Children** Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

CGP-3-DEP-90-3.0

B264.0007

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B449.0042

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

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

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

CGP-3-DEP-90-5.0

B200.0749

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

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

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

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

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

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

CGP-3-DEP-90-6.0

B489.0254

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

CGP-3-DEP-90-7.0

B200.0692

**Newborn Children** We cover your newborn child for dependent benefits, from the moment of birth if: (a) you are already covered for dependent child coverage when the child is born; or (b) you enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

CGP-3-DEP-90-8.0

B489.0019

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

## Dependent Coverage (Cont.)

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

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

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

An individual dependent's coverage ends when he or she stops being an *eligible dependent*. This happens to a child on the last day of the month in which the child attains this coverage's age limit, when he or she marries, or when a step-child is no longer dependent on you 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.

CGP-3-DEP-90-9.0

B489.0269



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## DENTAL HIGHLIGHTS

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

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

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

CGP-3-DENT-HL-90 B497.0075

- **Payment Rates:**

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

CGP-3-DENT-HL-90 B497.0087

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

For Group I, II and III Services . . . . . Up to \$1,000.00

**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.

CGP-3-DENT-HL-90 B497.1431

**Special Enrollment Period:** Once each year, during the group enrollment period from May 1st to June 30th , you may elect to enroll in one of the dental expense *plan* options offered by your employer, or to transfer to another dental expense *plan* option offered by your employer. Coverage under the new *plan* option starts on the July 1st that next follows election. Late entrant penalties do not apply to you and your *eligible dependents* if you enroll during this period.

CGP-3-DENT-HLTS B497.1468

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## DENTAL EXPENSE INSURANCE

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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.

CGP-3-DG2000

B498.0007

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### Covered Charges

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

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

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

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

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

CGP-3-DGY2K-CC

B498.0243

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## 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.

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## 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.

CGP-3-DGY2K-AT

B498.0002

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## 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.

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## Pre-Treatment Review (Cont.)

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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.

CGP-3-DGY2K-PTR

B498.0004

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## Benefits From Other Sources

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

CGP-3-DGY2K-OS

B498.0005

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## The Benefit Provision - Qualifying For Benefits

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CGP-3-DGY2K-BEN

B498.0072

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

- All Group II Services.

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

- All Group III Services.

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

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

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

CGP-3-DGY2K-LE

B498.0232

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## Benefit Provision - Qualifying For Benefits (Cont.)

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

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

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

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

CGP-3-DGY2K-BP

B498.0187

All covered charges must be incurred while insured. And we limit what we pay each benefit year to \$1,000.00.

CGP-3-DGY2K-BP

B498.0192

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## The Benefit Provision - Qualifying For Benefits

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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 Services" for details.

CGP-3-DG-ROLL-04-2.1

B498.2041

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## Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

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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.

## Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)

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

- *Rollover Threshold* . . . . . \$500.00
- *Reward* (if all benefits are for services provided by a *preferred provider*) . . . . . \$350.00
- *Reward* (if any benefits are for services provided by a *non-preferred provider*) . . . . . \$250.00
- *Bank Maximum* . . . . . \$1,000.00

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 provision of this *plan* called Penalty for Late Entrants and Waiting Periods for Certain Services, 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*.

## The Benefit Provision - Qualifying For Benefits (Cont.)

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**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*.

CGP-3-DGY2K-FL

B498.0073

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

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

CGP-3-DGY2K-PR

B498.0082

### After This Insurance Ends

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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.

CGP-3-DGY2K-END

B498.0234

### Special Limitations

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CGP-3-DGY2K-LMT

B498.0138

**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*.

CGP-3-DGY2K-TL

B498.0133

**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*.

## Special Limitations (Cont.)

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- **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.

CGP-3-DGY2K-PP

B498.0131

## Exclusions

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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.



## Exclusions (Cont.)

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- 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 un-like *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.
- Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.
- Any endodontic, periodontal, crown or bridge abutment procedure or *appliance* performed for a tooth or teeth with a guarded, questionable or poor prognosis.
- Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.
- Any procedure, *appliance*, *dental prosthesis*, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).

## Exclusions (Cont.)

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- Treatment needed due to: (1) an on-the-job or job-related *injury*; or (2) a condition for which benefits are payable 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*.

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## List of Covered Dental Services

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

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

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## Group I - Preventive Dental Services (Non-Orthodontic)

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**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 19 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.

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**Group I Preventive Dental Services (Cont.)**  
(Non-Orthodontic)

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.

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**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.

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**Radiographs** Allowance includes evaluation and diagnosis.  
Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 36 consecutive month period.

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

Other diagnostic radiographs:

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

Intraoral periapical or occlusal films - single films

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**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.

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## 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.

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**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

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

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

Injectable antibiotics needed solely for treatment of a dental condition.

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## 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

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## Group III - Major Dental Services (Cont.)

(Non-Orthodontic)

**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

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### **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

### **Group III - Major Dental Services (Cont.)**

(Non-Orthodontic)

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.

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## **Group III - Major Dental Services (Cont.)**

(Non-Orthodontic)

- 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
- CGP-3- B498.0209
- 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 one prophylaxis or periodontal maintenance procedure 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.



### **Group III - Major Dental Services (Cont.)**

(Non-Orthodontic)

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

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## **Group III - Major Dental Services (Cont.)**

(Non-Orthodontic)

**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

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## ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

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### Employee Vision Care Expense Coverage

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

**Other Conditions** You must enroll and agree to make required payments within 31 days of your *eligibility date*. If you fail to do so, you can't enroll until this *plan's* next vision open enrollment period.

This *plan's* vision open enrollment period occurs from May 1st to June 30th of each year.

Once you enroll in this *plan*, you can't drop your vision coverage until this *plan's* next vision open enrollment period. And if you drop your vision coverage, you can't enroll again until the next vision open enrollment period.

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

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B505.0060

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

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

CGP-3-EC-90-2.0

B505.0075

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

Your coverage ends on the date you die.

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

## Employee Vision Care Expense Coverage (Cont.)

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

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

CGP-3-EC-90-3.0

B505.0083

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

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

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

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

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

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

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

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

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- **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.

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## Dependent Vision Care Expense Coverage

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

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

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

CGP-3-DEP-90-2.0

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## Dependent Vision Care Expense Coverage (Cont.)

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**Adopted Children And Step-Children** Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

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

CGP-3-DEP-90-3.0

B505.0112

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

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

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

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B505.0119

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

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

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

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

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

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

CGP-3-DEP-90-6.0

B505.0714

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

CGP-3-DEP-90-7.0

B505.0132

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

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

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

CGP-3-DEP-90-8.0

B505.0153

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

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

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

## Dependent Vision Care Expense Coverage (Cont.)

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

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

CGP-3-DEP-90-9.0

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## VISION CARE HIGHLIGHTS

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

<b>PPO Copayments</b>	Examinations . . . . .	\$10.00
	Standard Frames and/or Standard Lenses . . . . .	\$25.00
	Contact Lenses . . . . .	\$25.00
<b>Non-PPO Cash Deductibles</b>	Examinations . . . . .	\$10.00
	Standard Frames and/or Standard Lenses . . . . .	\$25.00
	Contact Lenses . . . . .	\$25.00

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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.

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B505.0516

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## VISION CARE BENEFITS

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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.

CGP-3-DAVIS-05-VIS

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

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**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.

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

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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

CGP-3-DAVIS-05-PPOA

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### 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 contact the Missouri Department of Insurance Customer Department at any time for comment or to file a complaint. The toll-free telephone number is 1-800-726-7390. 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.

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### 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.

## Grievance Process (Cont.)

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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 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 grievance 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 their 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](http://www.davisvision.com) and entering the "Contact Davis Vision" area.

## Internal Grievance Procedure

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**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 their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their 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 them of the status of the investigation or the need for more information.

CGP-3-DAVIS-05-APP-1-MO

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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.

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## Internal Grievance Procedure (Cont.)

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**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.

The *covered person* requesting a Level 2 appeal must indicate the reason they believe the denial of coverage 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 statute, 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 and other enrollees 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.

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## External Grievance Procedure

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**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:

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## External Grievance Procedure (Cont.)

- 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.

CGP-3-DAVIS-05-APP-2-MO

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## 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.

CGP-3-DAVIS-05-HPW

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**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*.

CGP-3-DAVIS-05-COP

B505.0474

### **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.

CGP-3-DAVIS-05-VE

B505.0802

### **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 period, 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.

CGP-3-DAVIS-05-VM

B505.0805

### **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:



## How This Plan Works (Cont.)

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- \$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 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

CGP-3-DAVIS-05-SL

B505.0825

### **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.

## How This Plan Works (Cont.)

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 \$120.00. 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.

CGP-3-DAVIS-05-ECL

B505.0833

### 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.

CGP-3-DAVIS-05-NCL

B505.0489

### 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.

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## How This Plan Works (Cont.)

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 \$120.00.
- 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.

CGP-3-DAVIS-05-FRM

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## 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.

CGP-3-DAVIS-05-EXC

B505.0492

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## CERTIFICATE AMENDMENT

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The certificate is amended as follows:

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

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

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

**The Guardian** Life Insurance Company of America

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

CGP-A-1

B531.0022

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## CERTIFICATE AMENDMENT

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The certificate is amended as follows:

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

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

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

**The Guardian** Life Insurance Company of America

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

CGP-A-1

B489.0422

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## CERTIFICATE AMENDMENT

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Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of 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.

**The Guardian** Life Insurance Company of America

Stuart J Shaw

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DGOPT-10

B531.0029

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## CERTIFICATE AMENDMENT

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The certificate is amended as follows:

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

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

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

**The Guardian** Life Insurance Company of America

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

CGP-A-1

B505.1291

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## CERTIFICATE AMENDMENT

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Amendment Effective: On the later of January 1, 2012 and the effective date of your certificate.

This rider amends the ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE provisions of VSP's vision coverage, by adding the following:

**Vision Care Plan Election procedures:** Your *employer* offers a VSP vision care plan as an alternative to Davis Vision's vision coverage under this *plan*. You can enroll for either the VSP vision coverage or for Davis Vision's vision coverage, but not both at the same time.

If you are enrolled for Davis Vision's vision coverage under this *plan*, you may change your election and enroll in the VSP vision care plan during any open enrollment period, except you may not change your election until the end of any 2 calendar year frequency benefit period.

If you change your election, your covered *dependents* will automatically be switched to the VSP vision care plan at the same time as you.

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

**The Guardian** Life Insurance Company of America

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

CGP-A-1

B531.0077



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## COORDINATION OF BENEFITS

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**Important Notice** This section applies to all group health benefits under this plan; except prescription drug and vision coverage, if any. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

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

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### Definitions

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

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

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

## Definitions (Cont.)

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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.
- Hospital Indemnity Benefits** This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.
- Plan** This term means any of the following that provides benefits or services for health care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group or group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of \$100.00 per day; (6) medical benefits under group, group-type and individual automobile "no-fault" contracts, and under group or group-type traditional automobile "fault" type contracts; and (7) governmental benefits, except Medicare, as permitted by law.
- This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of \$100.00 or less per day; (ii) school accident type coverage; or (iii) Medicare, 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 health benefits, except prescription drug and vision coverage, if any, provided under this group plan.

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## 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 following rules that applies is the rule to use.

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

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

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

## Order Of Benefit Determination (Cont.)

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- (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.

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## **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. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this plan.

If the primary plan is an HMO and an HMO member has elected to have health care services provided by a non-HMO provider, coordination of benefits will not apply between that plan and this plan.

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## **Right To Receive And Release Needed Information**

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

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## **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.

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## **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.

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## GLOSSARY

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	This Glossary defines the italicized terms appearing in your booklet.	
	CGP-3-GLOSS.1	B750.0100
<b>Anterior Teeth</b>	means the incisor and cuspid teeth. The teeth are located in front of the bicuspid (pre-molars).	
	CGP-3-GLOSS-90	B750.0664
<b>Appliance</b>	means any dental device other than a <i>dental prosthesis</i> .	
	CGP-3-GLOSS-90	B750.0665
<b>Benefit Year</b>	means a 12 month period which starts on January 1st and ends on December 31st of each year.	
	CGP-3-GLOSS-90	B750.0666
<b>Blended Lenses</b>	means bifocals which do not have a visible dividing line.	
	CGP-3-GLOSS-90	B750.0781
<b>Coated Lenses</b>	means substance added to a finished lens on one or both surfaces.	
	CGP-3-GLOSS-90	B750.0782
<b>Copay</b>	means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a <i>covered person</i> before any benefits are paid by this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0783
<b>Covered Dental Specialty</b>	means any group of procedures which falls under one of the following categories, whether performed by a specialist <i>dentist</i> or a general <i>dentist</i> : restorative/prosthetic services; endodontic services, periodontic services, oral surgery and pedodontics.	
	CGP-3-GLOSS-90	B750.0667
<b>Covered Family</b>	means an employee and those of his or her dependents who are covered by this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0668
<b>Covered Person</b>	means an employee or any of his or her covered dependents.	
	CGP-3-GLOSS-90	B750.0669
<b>Covered Person</b>	with respect to vision care insurance means an <i>employee</i> or <i>eligible dependent</i> who meets this <i>plan's</i> eligibility criteria and who is covered under this <i>plan</i> .	
	CGP-3-GLOSS-90	B750.0784
<b>Customary</b>	means, when referring to a covered charge, that the charge for the covered vision condition is not more than the <i>usual</i> charge made by most other doctors with similar training and experience in the same geographic area.	
	CGP-3-GLOSS-90	B750.0785

<b>Deductible</b>	with respect to Vision Care Insurance, means any amount which a <i>covered person</i> must pay before he or she is reimbursed for covered services provided by a <i>non-preferred provider</i> .	CGP-3-VSN-96-DEF3	B750.0483
<b>Dental Prosthesis</b>	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.	CGP-3-GLOSS-90	B750.0670
<b>Dentist</b>	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 <i>plan</i> .	CGP-3-GLOSS-90	B750.0671
<b>Eligibility Date</b>	for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.	CGP-3-GLOSS.1	B750.0064
<b>Eligible Dependent</b>	is defined in the provision entitled "Dependent Coverage."	CGP-3-GLOSS.1	B750.0065
<b>Emergency Treatment</b>	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 <i>plan</i> .	CGP-3-GLOSS-90	B750.0672
<b>Employee</b>	means a person who works for the <i>employer</i> at the <i>employer's</i> place of business, and whose income is reported for tax purposes using a W-2 form.	CGP-3-GLOSS.1	B750.0101
<b>Employer</b>	means CAMDENTON RIII SCHOOL DISTRICT .	CGP-3-GLOSS.1	B750.0070
<b>Enrollment Period</b>	with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.	CGP-3-GLOSS.1	B750.0074
<b>Full-time</b>	means the <i>employee</i> regularly works at least the number of hours in the normal work week set by the <i>employer</i> (but not less than 20 hours per week), at his <i>employer's</i> place of business.	CGP-3-GLOSS.1	B750.0230

## Glossary (Cont.)

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<b>Initial Dependents</b>	means those <i>eligible dependents</i> you have at the time you first become eligible for <i>employee coverage</i> . If at this time you do not have any <i>eligible dependents</i> , but you later acquire them, the first <i>eligible dependents</i> you acquire are your <i>initial dependents</i> .	CGP-3-GLOSS.1	B750.0081
<b>Injury</b>	means all damage to a <i>covered person's</i> mouth due to an accident which occurred while he or she is covered by this <i>plan</i> , and all complications arising from that damage. But the term <i>injury</i> does not include damage to teeth, <i>appliances</i> or <i>dental prostheses</i> which results solely from chewing or biting food or other substances.	CGP-3-GLOSS-90	B750.0673
<b>Keratoconus</b>	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.	CGP-3-GLOSS-90	B750.0786
<b>Lenticular Lenses</b>	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.	CGP-3-GLOSS-90	B750.0787
<b>Newly Acquired Dependent</b>	means an <i>eligible dependent</i> you acquire after you already have coverage in force for <i>initial dependents</i> .	CGP-3-GLOSS.1	B750.0089
<b>Non-Preferred Provider</b>	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 <i>covered persons</i> of the <i>plan</i> .	CGP-3-GLOSS-90	B750.0788
<b>Orthodontic Treatment</b>	means the movement of one or more teeth by the use of <i>active appliances</i> . 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 <i>plan</i> does not pay benefits for <i>orthodontic treatment</i> .	CGP-3-GLOSS-90	B750.0685
<b>Orthoptics</b>	means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.	CGP-3-GLOSS-90	B750.0789
<b>Oversize Lenses</b>	means larger than a standard lens blank to accommodate prescriptions.	CGP-3-GLOSS-90	B750.0790



## Glossary (Cont.)

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<b>Payment Limit</b>	means the maximum amount this <i>plan</i> pays for covered services during either a <i>benefit year</i> or a <i>covered person's</i> lifetime, as applicable.	CGP-3-GLOSS-90	B750.0676
<b>Payment Rate</b>	means the percentage rate that this <i>plan</i> pays for covered services.	CGP-3-GLOSS-90	B750.0677
<b>Photochromic Lenses</b>	means lenses which change color with the intensity of sunlight.	CGP-3-GLOSS-90	B750.0791
<b>Posterior Teeth</b>	means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.	CGP-3-GLOSS-90	B750.0679
<b>Plan</b>	means the Guardian group dental plan purchased by the planholder.	CGP-3-GLOSS-90	B750.0678
<b>Plan</b>	means the Davis Vision plan of vision care services described herein.	CGP-3-GLOSS-90	B750.0792
<b>Plano Lenses</b>	means lenses which have no refractive power (lenses with less than a +/- .38 diopter power).	CGP-3-GLOSS-90	B750.0793
<b>Preferred Provider</b>	with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of <i>covered persons</i> of the <i>plan</i> .	CGP-3-GLOSS-90	B750.0794
<b>Prior Plan</b>	means the planholder's plan or policy of group dental insurance which was in force immediately prior to this <i>plan</i> . To be considered a prior plan, this <i>plan</i> must start immediately after the prior coverage ends.	CGP-3-GLOSS-90	B750.0681
<b>Proof Of Claim</b>	means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.	CGP-3-GLOSS-90	B750.0682
<b>Proof or Proof of Insurability</b>	means an application for insurance showing that a person is insurable.	CGP-3-GLOSS.1	B750.0099
<b>Standard Lenses</b>	means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.	CGP-3-GLOSS-90	B750.0795

<b>Tinted Lenses</b>	means lenses which have an additional substance added to produce constant tint.	CGP-3-GLOSS-90	B750.0796
<b>Usual</b>	means when referring to a covered charge that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.	CGP-3-GLOSS-90	B750.0797
<b>We, Us, Our And Guardian</b>	mean The Guardian Life Insurance Company of America.	CGP-3-GLOSS-90	B750.0683

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## STATEMENT OF ERISA RIGHTS

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

### **Receive Information About Your Plan and Benefits**

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

### **Continue Group Health Plan Coverage**

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

### **Prudent Actions By Plan Fiduciaries**

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

### **Enforcement Of Your Rights**

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

## Statement of Erisa Rights (Cont.)

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

### **Assistance with Questions**

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

### **Qualified Medical Child Support Order**

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

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

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

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

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

B800.0094

## **The Guardian's Responsibilities**

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B800.0048

The 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.

B800.0053

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

B800.0055

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

B800.0049

## **Group Health Benefits Claims Procedure**

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

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

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

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

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

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

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

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

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

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

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

## Group Health Benefits Claims Procedure (Cont.)

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

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

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

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

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

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

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

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

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

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

## Group Health Benefits Claims Procedure (Cont.)

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

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

### **Adverse Benefit Determination**

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

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

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

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

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

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

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



## Group Health Benefits Claims Procedure (Cont.)

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

In reviewing an appeal, Guardian will:

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

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

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

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

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

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

CGP-3-ERISA

B800.0076

## Termination of This Group Plan

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

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

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

B800.0086

## Life Insurance Claims Procedure

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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.

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

- (a) If a claim is wholly or partially denied, the claimant will be notified of the decision within 90 days after Guardian received the claim.
- (b) If special circumstances require an extension of time for processing the claim, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which The Guardian expects to render the final decision.
- (c) If a claim is denied, Guardian will provide a notice that will set forth:
  - (1) the specific reason(s) the claim was denied;
  - (2) specific references to the pertinent *plan* provision on which the denial is based;
  - (3) a description of any additional material or information needed to make the claim valid, and an explanation of why the material or information is needed;
  - (4) an explanation of the *plan's* claim review procedure.

A claimant must file a request for review of a denied claim within 60 days after receipt of written notification of denial of a claim.

- (d) Guardian will notify the claimant of its decision within 60 days of receipt of the request for review. If special circumstances require an extension of time for processing, The Guardian will render a decision as soon as possible, but no later than 120 days after receiving the request. The Guardian will notify the claimant about the extension.

If you apply for an extension of life insurance benefits due to total disability under an Extended Life Benefit under this plan, these claim procedures will apply to such request:

## Life Insurance Claims Procedure (Cont.)

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

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

If you fail to provide all information needed to make a benefit determination, Guardian will notify you of the specific information that is needed as soon as possible but no later than 45 days after receipt of your application for an extension of benefits.

If Guardian extends the time period for making a benefit determination due to your failure to submit information necessary to make the determination, you will be given at least 45 days to provide the requested information. The extension period will begin on the date on which you respond to the request for additional information.

If an application for an extension of benefits 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; and
- 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.

**Appeals of Adverse Determinations** If an application is denied, you will have up to 180 days to make an appeal.

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

## Life Insurance Claims Procedure (Cont.)

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- 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 you of its decision regarding review of an appeal as follows:

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

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

B800.0097

## Termination of This Group Plan

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

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

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

B800.0007



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

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

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

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

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

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

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



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

**The Guardian Life Insurance  
Company of America**

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New York, New York 10004-2616